CHANGE AND ITS MANAGEMENT IN A HEALTH AND HOSPITAL SERVICE

An analysis of the management of change in Canterbury Health Ltd, 1996-2000

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ABSTRACT

Within this case study, two perspectives upon organisational change are tested within the practice of management undertaken within the context of a New Zealand health and hospital service (HHS) over the last five years. This practice involves both the management of planned change and that of other associated, unplanned features related to changing environmental and internal circumstances. Data from key informant sources (clinical, managerial, and media) are analysed in order to assess the benefits and costs of the particular, dominant management style adopted within this HHS over this period. By and large, Canterbury Health has experienced positive change outcomes despite a change management approach over the period 1996-2000 that did not engage people, particularly clinicians. As the respondents in this study point out, some of these changes were necessary. The positive change outcomes are documented in this paper through detailed case studies. The chief implication of this thesis, however, is that the process of handling change (especially, involving the addressing of challenge and conflict) should have been managed differently. Clinicians could have been engaged more actively in this process. Results of this choice of management style are contrasted, producing implications both for the management of health and the management of change. These implications are applicable to all human profession sectors. Conclusions based on data and the personal opinions of the author are presented inside the last section of this paper.

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Forward, forward, let us range.
Let the great world spin for ever down the ringing grooves of change.

Alfred, Lord Tennyson, *Locksley Hall*, 1, 181

Tempora mutantur, et nos mutamur in illis.
(Times change, and we change with them.)

Harrison, *Description of Britain* (1577), iii, 99

Tempora mutantur nos et mutamur in illis: quomodo? Fit semper tempore pejor homo.
(Times change, and we change with them too. How so? With time men only the more vicious grow.)

Owen, John, *Epigrams*

The only limit to our realization of tomorrow will be our doubts of today.

Franklin Roosevelt

INTRODUCTION

Change in the health services can be seen as a seismic societal paradigm shift occurring throughout the world. It will not be attempted to define this shift right now. Suffice to say, New Zealand has not been left untouched by this sweeping shift, this spirit of our time, and this shift has profoundly affected the manner in which health is administered and overseen in this day. It is a shift that has realtered health management structures, reshaped health management priorities, and redesigned standard health management practice, erupting upon, within, and out from the very heart of the way that management operates.

Change can be defined as any alteration or movement away from an accepted state of events or breaking with tradition.Its antithesis can be said to be the status quo. Attitudes towards change differ dramatically. The first three epigraphs chosen for the opening section of this thesis demonstrate this (the other two were chosen to remind the reader of the connection of time in the process of change). From Tennyson's progressive and optimistic outlook to Owen's cynical parody of the pragmatic Latin colloquialism regarding the constantness of time and our involvement within it, a full range of attitude is presented. This illustrates both the diffuse and complementary

nature of change. Change affects for both the better and the worse. It is regularly both at once. Whether it is good or bad is very much a matter of perspective. Often one's attitude upon change will depend upon how much the change process affects oneself.

This thesis examines the approach to change adopted by the management of Canterbury Health Ltd over the last five years within Christchurch Hospital's broader context, that of Canterbury Health Ltd. This institution is the key provider in the local health sector of which Canterbury Health Ltd is a recipient of state funding along with Heathlink South. Through this paper, the way that change has been managed in this particular organisation will be scutinised. Christchurch Hospital is the most prominent part in the chain of institutions that Canterbury Health Ltd is responsible for. It serves as an excellent example of the way that change has been managed in the whole of this health and hospital service (HHS) over the period of time from 1996 through to 2000. This style of management will be assessed using a two part model.

Discussion of the integration of a number of apparently opposite paradigms in the field of organisational theory as it relates to change management follows within this paper. In the introductory sections of this section, two divergent approaches to planned change management, namely 'economic' and 'developmental' approaches, are discussed. Two divergent paradigms used in understanding the process of change management, namely those of a 'planned' and 'emergent' nature, are then discussed. These two separate areas of dichotomy share certain parallels as the differences between each of their sub-components lie in similar underlying rationalities and due processes. In the middle sections of this thesis, integration of these sets of divergent perspectives is used to analyse change management methods from 1995 within the respondent organisation.

Within later sections, a third area of divergence in perspective is also addressed which shares similar parallels also. This divergence is within the traditional, extensive, and exhaustively written about topics of 'management' and 'leadership'. The final sections of this paper are then devoted to implications which draw together these three disparate areas of paradigmatic divergence into discrete 'wholes' that are recommended to be implemented in application to the end of better understanding how change management in the national public health system should be accomplished. Conclusions are drawn on the basis of specifics gathered from the case. Stemming from the inherent representativeness of the HHS in question, comments will not be restricted to it, as an organisation, alone. General comments will also be made that relate to the national health system.

This case study grows from the simple aim of trying to relate the widespread body of theory about the nature and process of change management to the practical involvement of managers in the administration of such a process. This study investigates the relevance of current models of change management. For a plethora of recipes for successfully implementing organisational change is found in the body of literature that exists upon the subject. This abundance could suggest that theory typically underpins the implementation of change in organisations. The chief assumption here seems to be that (a) organisations are aware of this theory, and (b) that knowing this theory they see the usefulness in applying it and, in reality, do apply it. Whether or not this is so in reality would be the alternative hypothesis of this thesis if it were a quantitative piece of work.

But it is not. Rather, this thesis seeks to understand the way that change is managed in an organisation and then to compare this with extant theory in order to draw conclusions of relevance to both the fields of health and management. Its methods are qualitative in origin and purpose, sidestepping the hypothetico-deductive research model in favour of an inductive, interpretative approach marked by a reliance on multiple sources of information.

Its aim is to "produce a more or less coherent representation, carried by word and story, of an authorially claimed reality and of certain truths or meanings it may contain for those within its reach" (Van Maanen (ed.) 1998:xi). It is hoped that within it events are linked in a dramatic and storied form (with beginnings, middles, and ends) in a manner, which explicitly connects elements of the story. In this way it is the expectation of the author that this research study will emplot a "casual structure that ... is made theoretically plausible through argument and analogy" (Van Maanen (ed.) 1998:xi).

From the discussion that starts in the next section, a conceptual framework relating to organisational change is devised that will then be applied to Canterbury Health Ltd's performance in managing change over the last four years, the period for which Richard Webb (hereon referred to as 'the CEO') both committed himself to be and acted as chief executive officer. Which of 'economic' or 'developmental' approaches to change management apply best to the history of this organisation under the CEO?

It is hoped that this framework will serve as a useful point of contrast to Canterbury Health Ltd's particular change management practice and be relevant to what current

academic theory prescribes. From the body of descriptive research that follows from this framework, guidelines to better health management are finally inducted. These guidelines are to be found nestled, along with express comments of opinion by the author, in the final two sections of the paper.

PART I A BACKGROUND TO THE STUDY OF THE MANAGEMENT OF CHANGE

LITERATURE REVIEW: THEORETICAL PERSPECTIVES

The area of change and its relation to organisational management is an area that has been treated extensively in theoretical academic literature. The implications of this literature for the practice of management are similarly broad. In this section, a framework for analysing change will be developed with reference to a range of approaches, drawn from this wide implicative field of literature, that have been previously used in making analysis within the organisational domain.

It is useful to begin a discussion of change management by outlining the approaches taken within prior literature on change management in order to provide points of contrast and departure for an alternative approach to understanding change management phenomena. Change can be represented and treated as either a planned process or an unplanned and emergent process (Wilson 1995). The comments of this thesis variously focus upon both of these aspects of the process change in turn at a later point. First, however, attention is given to an area that provides basis for discussion of these different approaches with precision and clarity, the area of underlying value. This is an area which gives insight itself into an evaluation of the different approaches that can be taken to change management (Dunphy & Stace 1996).

Different competing theoretical frameworks for the management of planned change

The theory of the management of change is marked by clear divergences in approach. Many different variables act as guidelines for the analysis of such change. The business field is proliferated with mass-marketed management advice for how to make change, when to make change, and most importantly, what changes to make. Novelty in form but not substance is typical of such advice. In a style reminiscent of a Dilbert cartoon strip, Van Maanen points out that "nowhere is the penchant for fad and folderol more prominent than in the managerial discourse surrounding organisational identity and change" (Van Maanen (ed.) 1998:193).

In evaluating different competing frameworks, theories or models of organisational change one has to be aware of the differing values bases that underlie such constructs. Values cannot be positivistically assessed or empirically verified and legitimated. Nonetheless, values and ideology necessarily infuse theory. This subjective driver understood to be values-based is critical in understanding why change actually occurs. Theoretical frameworks of organisational change are simply approximations and reflections of how change takes place in reality. They are strongly affected by their socio-historical context (Dunphy 1996). As such, they reflect differing and, in some cases, enduring personal views towards change and how it should be implemented.

The framework that this paper uses to describe and compare the nature of organisational change implemented within Canterbury Health Ltd (1996-2000) relies on a bipolar approach to the issue of values as they pertain to the subject of change in organisations. The parameters chosen for this framework, in a broad sense, represent the two most dominant theoretical approaches to the subject of organisations throughout the twentieth century, namely scientific management and the Human Relations school of thinking. It is a unified framework in that it is composed of two supplementary paradigms that cover a Western history of industrial and social interaction but it is not a unified framework in a simplistic or illusory sense. As we shall see, the extremes of its model are steeped in values that are essentially distinct from each other.

Different competing values systems within the process of planned change

Values underlie any approach. To deny this, is to overlook the fact that values exist, due to their innately human connection, wherever people are found. Indeed, change is a clearly multifaceted activity. Change impacts upon a number of different business levels and involves a number of modes and dimensions in so far as organisations are concerned. For example, people can be viewed as the chief recipient of change. This is a sociological approach and was introduced into mainstream managerial thinking by the Human Relations school that developed out of research in the 1930's. This school of thought is now best demonstrated in the socio-technical systems approach of Emery and Trist. Alternatively, one can rightfully view non-human systems that lead to productivity as the major focus of change. This is an economic approach. Such has been the basis for the predominant opinion and leaning in sentiment of Western business leaders for the last two decades.

What can be called a 'developmental' approach stems from the first of these ways of thinking. It regards and views people in the first instance as the prime focus of organisational change. This exchange from change to people occurs at the socio-technical interface. The latter perspective upon change is neo-Fordist and based on typically modernist principles. It regards system alteration, adjustment or creation as the key transformation points of change. This is wrested in producing cost reductions and net economic gains. As a counterpoint to the intrinsic and human centering of the 'developmental' perspective, such an 'economic' perspective is geared toward leveraging positive results from organisations primarily through changes in methods (not people).

There are two broad approaches to organisational change. One takes the organisation as the unit of change, and redesigns the structure and roles within that structure. This is a characteristic of what shall hereon in be described as an economic approach to change management. The other takes the individual as the unit of change, and develops the competencies of people. This is akin to what shall be forthwith described as a developmental approach to this management. Ultimately, both approaches have to be utilised if lasting change is to be realised.

An economic approach to the management of planned change

In the following section, what this paper refers to as an 'economic' approach toward organisational change and its management is explained. This approach toward management is underpinned by positivist agency theory, a popular theoretical conceptualisation upon the way that organisations operate in practice that has been in currency for over the last decade. This particular paradigm, distinguished from principal-agent research (Scott & Gorringe 1989), contains key implications for organisational theory and various influences upon current organisational change management practice due to its perceived validity in the present practitioner base. It highlights the driving thoughts behind an 'economic' approach to change and, as such, is discussed in the context of this paper.

Classic economic approaches to change management emphasis the need for strong formal rules, regulations and procedures. Under this approach, motivation is gained through extrinsic financial rewards. These are core notions of an 'economic' approach to the management of change. In recent times, this economic approach has been given

prominence and popularised under a new conceptualisation in the field of organisational analysis, that of agency theory. In short, this theory suggests that the effects of actor behaviour based on economic motivation and the negative consequences of these actions are best controlled and mitigated through such control from the level of the principal.

An 'economic' approach towards change and its management has gained support over recent times by a marked increase in theory upon organisations drawn heavily from an economic perspective (Donaldson 1995). As Johnson (1987) notes, the teaching of strategic management from the mid-1970's has been drawn from this economic and operational research basis rather than theory having any strong links with the disciplines of social inquiry. These analytic frameworks are growing in popularity too (Donaldson 1995). They tend to be dominated by positivists who are "anxious to develop laws or rules ... that [can] somehow be shown to be proven and presumably used a more or less prescriptive guidelines for managers" (Johnson 1987: xiii).

Extensive writing upon the relationship between economic theory and practices that occur within organisations can be found within academic literature during this period. This is testament to a concerted effort by proponents of economics to maintain the application of orthodox economic notions in a post-modern context (Rumelt, Schendel & Teece 1991). This proliferation is built largely upon aspects of positivist agency theory, an idea that is rooted firmly within classical economics. This notion of positivist agency theory is explored later. At this point, it is appropriate to make clear that the related mathematical theory of agency (i.e. principal-agency research as distinguished from agency theory) is not an element in the thinking that is behind what 'agency theory' refers to within the bounds of this paper.

Firstly, however, it should be explained that a relationship between economics and organisations is by no means a new phenomenon. Economics has had a central influence over traditional forms of industrial organisation (Rumelt, Schendel & Teece 1991). Fordist principles of organisation, process and management, along with other modern 'scientific' approaches to management, revolve heavily around those economic principles of specialisation, economies of scale and division of labour (McLennan 1987). Strategic management and economics, while not the same thing, are closely linked by tradition also. Economics has made a great contribution to the development of management this century and strategic management has clearly profited from the infusion of this thinking, as the work of Alfred Chandler displays (Whittington 1993). The similarity of objectives between the two areas is striking. As

economics is chiefly concerned with the performance of markets in the allocation and co-ordination of resources, strategic management focuses on co-ordination and resource allocation inside the firm (Rumelt, Schendel & Teece 1991).

Positivist agency theory looks to build on this 'economic' contribution to an understanding of organisations and management. To a degree, it has permeated into the present ideology of management and offers much promise to some in the construction and maintenance of such a mindset (Jensen & Meckling 1976). It also has its detractors. As a credible or whole framework through which to view management in the present day, some argue that economic-based theory has its limitations (Donaldson 1995; Nilakant 1994). A holistic approach, which includes an 'economic' approach, based on a balanced critique, is argued for in application to the management of health within a later section.

Positivist agency theory essentially explicates that individuals in human relationships often possess a role of either agent or principal and then concerns itself with resolving the inherent problems that occur in these relationships as it defines them (Eisenhardt 1989). It is a behavioural theory that focuses on the individual as the unit of analysis. As a result of this individual unit focus, aspects of context involving groups and organisations are left to the side.

From the research of Jensen, Fama and Meckling (Jensen & Meckling 1976; Fama & Jensen 1983) the theory has developed along two lines: positivist and principal-agent. Positivist researchers have focused on identifying situations in which the principal and agent are likely to have conflicting goals and then describing the governance mechanisms that limit the agent's self-serving behavior. Principal-agent researchers are concerned with a general theory of the principal-agent relationship. The heart of positivist agency theory is the goal conflict inherent when individuals with differing preferences engage in cooperative effort (Jensen & Meckling 1976). Particularly in the large modern corporation, the principals are owners, the many outside shareholders, who own but delegate control to the executive managers who are their agents (Donaldson 1995; Fama & Jensen 1983).

Empirical studies of positivist agency theory mirror the two streams of theoretical agency research. In the positivist stream, the common approach is to identify a policy or behavior in which stockholder and management interests diverge and then to demonstrate that information systems or outcome-based incentives solve the agency problem. The principal-agent stream is more directly focused on the contract between

the principal and the agent (Eisenhardt 1989). Both provide similar frameworks for analyzing the interaction of self-interested individuals within an economic context, however, they emphasize different sources of the divergence between cooperative and self-interested behavior (Baiman 1990). Nonetheless, Nilakant (1994) points out that criticism of one can be equally validly applied to the other. For the sake of time, the discussion of agency theory within this paper is limited to only positivist agency theory.

As a theory that focuses upon the individual as the unit of analysis, positivist agency theory attributes the greater part of an individual's performance to behavioural characteristics. A central tenet of positivist agency theory in the context of performance management is its equation of the value of performance output to a function of the effort of the individual agent, along with a combination of random elements. Through their discussion of positivist agency theory, Jensen and Meckling (1976) propose a definition of the organisation that views this phenomenon as a simply legal fiction that serves as a nexus of contracts among various factors of production. This is an economic view similar to that of another economic theory of organisation which considers organisations through the nature and character of its various 'contracts', 'transactions' and transaction 'governance mechanisms' (Williamson 1975).

The implications of positivist agency theory for the management of an organisation are clear. A degree of supervision, moral hazard, and hierarchical control is required to be both accepted and exercised by those that hold principal roles within employment relationships in order to derive optimal results from agents (Yang 1995). Control can take the form of incentives (Kosnik & Bettenhausen 1992; Fumas 1993), variously output-based (e.g. high performance, Holmstrom & Milgrom 1994) or behaviour-based (Rao 1997) and is especially needed where agent roles are ambiguous and agent skills are low (Rao 1997). Compensation systems are an important part in performance management.

Control can also take the place through the use of thorough information systems that lessen the chance of agent duplicity going undetected (White 1992; Choudhury & Sampler 1997). Other forms of control include granting workers the ownership of assets and thus increasing motivation by increasing participation (Holmstrom & Milgrom 1994). This is less coercive and more indirect form of control. It is open for criticism as manipulative (Willmott 1993).

Without which such supervision and control, the claim of positivist agency theory is that agents are liable to be opportunistic, self-seeking and deceptive (Donaldson 1994). Moral hazard results from the limited ability of the principal to assess agent effort due to random factors, conditions of imperfect information and the stochastic nature of the environment (Yang 1995). Cowen and Glazer (1996) provide an interesting counterpoint to the dominating ideas of positivist agency theory. They suggest that increased monitoring can induce less effort from agents. To this point, positivist agency theory has no definitive reply (Donaldson 1994) although Holmstrom and Milgrom (1994) suggest that worker freedom from direct control is a complementary instrument for motivating employees.

There are two crucial elements to the argument of positivist agency theory. One element lies in what economists refer to as individual utility maximisation assumption which positivist agency theory explicitly employs (Noorderhaven 1992). Individuals, both agent and principal, are averse to risk and attempt to maximise personal financial gain. The other element regards information as a positive cost. Positivist agency theory views both the transfer of it between parties and the monitoring of agent behaviour through systems established to collect it as costly (Noorderhaven 1992). In the first case, cost applies to both the agent and the principal. In the second, cost is borne by the principal alone.

This theory then applies to management in the following way. Management attempts to avoid costs through agent behaviour. This applies to both formal and informal contracts of and for work. Therefore, when an organisation is predominantly viewed as operating under the principles of positivist agency theory, an accurate accounting system information provides a critical support to management in its prime function of managing an organisation and change within that organisation. The principles of positivist agency theory view individuals as actors that must be controlled. Accounting information provides a basis to regulate and maintain individual action upon.

It is precisely this view that formed the basis to New Right ideology that has become institutionalised as the acceptable 'business' philosophy of today (Nilakant 1994). Declining performance is seen to be able to be arrested upon understanding its implications and applying these. This ideology has been applied to health care over the last decade with the argument being that health institutions need to become market-driven and managerial in their orientation.

Specification of performance standards coupled with incentives has been widely believed to lead to accountability and better performance under the influence of this approach (Nilakant 1994). Private sector elements have been transferred into the public sector under the state sector reforms of the last decade. Some of these elements have aimed to overcome agency problems by various controls, such as the reduction of hierarchy and accrual accounting-driven, output-based system foci. These seek to utilise direct accountability in order to increase financial efficiency (Scott & Gorringe 1989).

As Jacobs (Jacobs & Nilakant 1995; Jacobs 1995) notes, the fixation upon control, numbers and rules within positivist agency theory has been mirrored in the post-reform years of the 1990's inside the national health system by an increased preponderance upon budgeting, planning and contract formation. This approach is supported by positivist agency theory. Forgione & Giroux (1989) demonstrate positivist agency theory's usefulness in analysing the effects of changing economic relationships within business upon this same basis, that is the demand for and formulation of accounting standards within the health care industry. How positivist agency theory has been translated into practice within Canterbury Health Ltd under the CEO's ostensible guidance shall be discussed in later sections.

Expanding on this, an 'economic' approach to change management based on positivist agency theory prescribes the use of rules and procedures by managerial principals to constrain organisational agents in order to meet the objectives of the proposed management of change. Barney and Ouchi (1986) use the term organisational economics to describe theoretical contributions to organisational theory from economics. Agency theory and transaction cost theory are not the only contributions (Barney & Ouchi 1986) but they are among the most influential formulations on organisation theory to have arisen from economics to date (Donaldson 1995). This 'economic' approach will now be discussed further, away from agency theory specifically, but building upon what has been said on this matter.

Much current thinking about the strategic management of change has derived from a classically rooted basis. In the past two or three decades this thinking has been dominated by an anxiety to develop laws or rules of strategic development that could somehow be shown to be proven and used as more or less prescriptive guidelines for managers (Johnson 1987). These frameworks are based on notions that stem back to a much earlier part of the twentieth century. The roots for this thinking are there found to lie in scientific approaches to management that stressed the presumed ability of

people to be able to make objective assessments of reality and act rationally in achieving explicit goals relating to rightly identified solutions. The purpose of management in such a case was to make decisions and pass these to inferiors in a top-down fashion at which level they were enacted.

This view is somewhat akin to Johnson's (1987) description of a rationalistic model of strategic management. Using a rationalistic model, strategy is formed through a combination of analytical and evaluative processes on the part of managerial cognition and centered upon an external, knowable environment. This model emphasizes the ability of the manager to identify and implement correct courses of action for the organisation that they represent. Uncertainty and complexity can be reduced through comprehensive cognitive analysis, such analysis yielding explanations of cause and effect in terms of organisational performance. This view of strategic change making is step-by-step and linear in process. It depends on clear objectives that permit measured evaluation of strategic options, these options being evaluated against the 'facts' that are established through analysis and the explicit objectives of the organisation. Strategic decisions are the domain and property of top management. Other managers either service such decisions or implement them (Johnson 1987; Whittington 1993; Johnson & Scholes 1997).

The essence of the managerial task thus becomes one of establishing rationality, or some predictability, out of the seeming chaos that characterizes change processes. According to this sort of strategy, the human capacity to think rationally and act effectively is very high. This is characteristic of what can be described as Classical strategy (Whittington 1993). This technical managerialist approach is based upon the flawed assumption that practice follows policy almost like night follows day (McCabe, Knights, Kerfoot, Morgan & Willmott 1998). Traditional approaches to management have utilised such an approach as a guide. Both economic approaches to the management of change and rational approaches to the management of strategy possess similar elements and similar starting points.

A classical, economic approach to strategy has distinct implications for the strategic management of change. Firstly, it assumes that managers can actually achieve successfully through personal expertise and thorough planning. "Profitability is the supreme goal of business, and rational planning the means to achieve it" (Whittington 1993:11). It is a role that requires managerial detachment and careful control of the change process, not through intimate involvement in operations but through formal oversight. This detachment is partly necessary for psychological reasons. It does,

however, ignore that strategy might need to be appropriate to the particular social context that it is a part of and requires the involvement of others at all levels of the organisation in order for it to be successfully achieved. Whittington (1993) refers to this consideration as 'sociological efficiency'. It also ignores that successful achievement might involve other factors apart from that of economic profit. It assumes that a strategic path should be identified and purposefully followed rather than keeping options less prescribed.

The focus of this type of approach is fundamentally outside of and away from of people (where people and economic rationality clash). It is, in part, based upon notions drawn from economic ideas related to rational optimization. Profitability and efficiency are typical catch-cries in the promotion of this approach. Quality is seen to stem from these end-state goals, through the use of (not innately because of) the people that produce them. People do not possess these values inherently. Such a view does not, however, suitably take account of the political and cognitive realities of organisations. Developmental approaches to change, such as that espoused by a range of management theorists (e.g. Schein, Argyris, Stace, Senge) take a different line.

The consequences of sustained 'economic' management systems are all too clear (Golembiewski 1989). People tend not to surface real problems, ideas or feelings. Organisational members experience a diminished sense of psychological success. Material gain is possible for those with sharpened contract negotiation skills (agency theory). Withdrawal, either physically through absenteeism or psychologically and affecting turnover and quality, increases. Conflict and low levels of energy are heightened. Such systems if dominated to excess by 'economic' concern can become self-reinforcing in a very limiting way.

Agency theory and its associated economic concerns can be quite clearly linked to the context of change within the New Zealand health system over the last decade. For example, the NZ reforms over this time were driven by economic thinking of the type that underlines the thinking of this theory, with its associated focus on clear incentives, sub-system accountability (i.e. both managerial and clinical) and accounting practice (Scott & Gorringe 1989). In a later section these changes will be analysed more deeply and in connection with the specific situation of Canterbury Health Ltd. For now, it is sufficient to say that national health systems generally across the world have undergone change over the last period of history for reasons of an economic design.

Agency relationships occur when one party (the principal) hires another party (the agent) to act on the behalf of the former. Maclean (1989) describes how agency problems have significant implications for the health care system in terms of a potential impeding of efficiency and raising of costs of care for the consumer from the public. Maclean (1989) suggests that the formation of complex financial contracts helps resolve agency problems. Such a view, as already mentioned, has increased in popularity over the last decades as senior managers have been shown to be more unreliable through the basis of an accrual of cases and incidents over time. Management can affect health provider performance adversely. This recognition has spurred on economic theory, such as that of agency, which recommends extra control being placed over management.

It is not the only view of management in health and generally however. The fact that managers can and do manage effectively as governors for wider stakeholders is not lost on most. This view of managers as responsible actors in health management is sustained by the findings Molinari, Morlock, Alexander & Lyles (1993). Their results support the view of a managerial theory of governance, that is, that the expertise and knowledge of insiders enhance rather than impair hospital financial performance. These two views of management in health are typical of the perception and reality of managers generally. They are the two extremes and many managers fall amidst the two types. Together they set the backdrop for the rest of this study, introducing, as they do, notions of economic performance and an economic approach to this performance and its management.

A developmental approach to the management of planned change

Organisation development (OD) rests "on a substantial 'solid core' of values and empirical regularities" (Golembiewski 1989:14). From this, Golembiewski (1989) describes how the normative thrust of OD involves four key variables, those of openness, ownership, risk and trust. He illustrates how these variables possess an operational quality and overlay. These variables, he concludes, can then be denoted as meta-variables as far as OD is concerned. A spirit of inquiry, intentional helpfulness, human relationships and a sense of community are its attributes. It can be seen that from a theoretical standpoint a 'developmental' approach to organisational change management might be characterised by quite a different set of values than an 'economic' approach. Core notions of openness and trust reside at the centre of what constitutes a 'developmental' approach to the management of change.

In my view, OD can be appreciated best by its focus on the individual and group as opposed to the organisation as a whole or the context of a business unit. These are, naturally enough, the primary areas of concern of an 'economic' focus. OD is far more interested in the human dynamic and externals that are inputs into this dynamic than the external output or product of this human dynamic. It can therefore be contrasted with the 'economic' approach already discussed in this regard. OD has an intra-people focus, centers on intrinsic factors and satisfiers, and is commitment-based. This contrasts sharply with the other approach already mentioned. OD initiatives include the identification of a target culture with is going to meet future business needs, leadership development, behavioural competencies, organisational climate surveys and focus groups and various corporate training programmes aligned with strategic business needs.

Such a view can be neatly embellished through the use of the conceptualisation of a senior academic also upon this matter as it affects that manner in which organisational change should take place. Schein (1985) holds that members, and not just management, define the minutiae of expected organisational behaviour. Thus, in enacting transformational change, the manager or change leader must intervene in a both a direct and a human fashion. Part of this is through direct contact and communication but perhaps more important than what the leader says is their symbolic communication through actions and behaviour. Direct and command-based methods of communication are commonly utilised in an 'economic' approach to change. This can be complemented by the more subtle OD approach of symbolic communication and individualised treatment.

Systems governed by such values can also become self-reinforcing. The difference is that heightened senses of responsible freedom and positivity are more likely to be the outcome. Personal and system regeneration and interaction are significant parts of this positivity. In Johnson's (1987) terms, this approach to the suitable management of change is akin to an incremental model of strategic decision-making. In both cases, outcomes are the product of the action of corporate life, social and political activity, and the routines of the organisation. These outcomes can rightfully viewed as compromises, designed as they are to accommodate conflicting power groups in competition for organisational resources. Change develops through small, serial steps. It occurs in an evolutionary, if intermittent, pattern. Problem awareness is likely to be at an individual and qualitative level initially. The impetus of change is found in organisationally relevant triggers, e.g. related to performance management.

One can consider the terms of Table 1 as idealised nomenclatures for what is understood to be 'soft' change and, on the other hand, what could be called a 'harder' approach to change. In this case, 'hard' can be understood to represent 'economic' and 'soft' as 'developmental'. Both economic and developmental approaches to change contain values that are so robust that they are certain to endure, despite the locus of power and the domain of an organisational context. In many cases, the differences between these approaches are almost antonymous. Table 1 outlines suggested characteristics as to these differences.

Economic approaches follow a rationalistic model toward strategic change and decision-making; developmental approaches, an incremental approach to such change (Johnson 1987). It should also be noted that each approach has different products and emphases. The former selects strategies that emphasise efficiency, control and accountability (with economic forms of optimality) while the latter selects strategies that emphasise learning, co-operation and consensus (with implicit systemic-ethical forms of optimality). It is one of the paradoxes of life that, in some cases, the latter type of strategy is the more effective approach. This effectiveness stems from the broader outlook of non-traditional forms of decision-making, which take into account a wider scope of interest parties.

What in this paper is referred to as a 'developmental' approach towards management subsumes an element of a socially constructed view of organisational reality. Such a view incorporates intraorganisational politics and the tensions of hierarchy into its schema. As a result, social managerialists, taking the general developmental approach to management into account, recognise that outcomes are always a negotiated compromise day (McCabe, Knights, Kerfoot, Morgan & Willmott 1998).

At the end of the day, both aspects of both approaches are required. It is not enough to simply observe or listen to the many 'voices' of change. Nor is it simply wise to command instruction after instruction in an autonomous, autocratic manner and hope to control change by this method. All of reflection, discussion and action are required to make change meaningfully and powerfully in the context of the dynamic environment that constitutes most organisations. In many cases, a synthesis of the proposed variables under 'economic' and 'developmental' approaches to planned change will result in the introduction of a third variable, that of 'total change management'. This products of coalescence can be thought about and entitled as seen

fit by the reader as the implications of this paper are unfolded. This coalescence and synthesis will be described in due course within this section.

Table 1

Emphases of change

Developmental emphases	Economic emphases
Determination to learn (for human growth)	Determination to achieve (despite human cost)
Employee stakeholder	Corporate shareholder
Flexibility for goal-achievement	Rigidity of purpose
Group perspective	Business-unit perspective
High trust, reliance and co-operative relations	Non-disclosure or lack of information-sharing
Honesty	Duplicity e.g. agent vs principal
Human resource management	Management accounting
Interpersonal relations	Power relations
Intra-people	Extra-people
Long-term outlook i.e. years	Short-term i.e. annual report
Observation	Command
Openness	Directness and abrasiveness
Owning	Controlling
People	Profit
Understanding of human dynamics	Production of financial returns
Consciousness of the products of human interaction for the purpose of transcending these products	Awareness of bottom line considerations for the purpose of maximising future returns on these considerations

To further illustrate the differences between these two perspectives, another framework produced by Hornblow (1997), and kindly reproduced with express permission by the author, is shown below. This framework can be seen to neatly bolster and mirror the conceptualisation of this paper (Table 1) in a number of key regards.

Firstly, based on this model, there appears an inherent difference between two of the chief players in health management in terms of their respective approach to the job of health management. Based on Hornblow (1997), much of the focus of clinicians is in

line with what has been prior described as a people-based or 'developmental' approach to change. On the other side of the paradigm, an approach to change subsequently referred to as 'economic' seems to be considerably aligned with a corporate management perspective, taking account less sufficiently, as it does, of an internal view of people.

Table 2

Dual emphases involved in health

Clinical emphases	Commercial emphases
Cure, care outcomes desired	Profit, growth outcomes desired
Compassion, excellence values	Competition, efficiency values
Health sciences language	Business management language
Collegial decision making	Hierarchical decision making
Health status, pathology, treatment, patient risk management knowledge base	Market forces, commercial risk management knowledge base

(Based on Hornblow 1997 and reproduced with permission)

Remember, this is neither a statement nor judgement of individual values but rather an objective expression of what has been seen in practice to be a generalised manner of and motivation behind action of these two groups.

Secondly, this framework provides a useful means by which these parties can be assessed in action. As a parallel piece of conceptualisation to the framework proposed to be the basis for this paper (Table 1), this model sits as a counterpoint to the position demonstrated by individual respondents in interview situations. The results of these interviews will be clearly reported in later sections of analysis.

This then sets the scene for more discussion about other tenable approaches to change. The direction that this paper is then taking with respect to analysing change should already, however, be clear. It is based on the model of Table 1.

Planned and emergent approaches to change

Any analysis of change is based on assumptions. The approach chosen in so doing is fraught with having to select a method or methods from a range containing immense divergence across theoretical, empirical and epistemological issues (Wilson 1995). This fact makes an important point. The study of change is not to be found contained or described within the boundaries of one approach. Sometimes a particular approach is better or more useful than another. All though, quite conceivably, contain potential benefit to the analyst.

To this point a central assumption has been made about the nature of change and its management. That is to say, change and its management have been viewed as being planned and able to be controlled through the choice of a particular approach ('economic' or 'developmental'). This is not the only contention that exists as to this point however. Two general approaches to a consideration of the process and implementation of change exist: planned and emergent approaches.

They are interlocking in the sense that they complement each other and describe aspects that the other fails to open upon as fully. Both are essentially drawn from quite different academic traditions and disciplines. The first of these is that change can be planned, defined by its central assumption that change can be prepared for and enacted by the conscious decision and will of people. It is a voluntaristic model.

The second approach assumes and suggests quite an opposing core thought. Change is fashioned through both the inadvertent and intentional interplay of actions made by and between people. This is a model that relies on change being no more than a function of antecedent and political factors and processes. It is based much more on the deterministic premises of social science.

Planned approaches to change focus upon what can be managed by people in terms of making change happen. It selects to focus on what is possible and proactively so. The sharing of vision within organisational communities, thus transmitting change in a controlled manner by producing a need and a commitment to change, has provided a popular start to many such planned models. Its key emphasis is upon lessening the effect of previously strong elements that might prevent this transmission of vision producing desired results of change. Under the umbrella of planned change approaches, both short and long timeframes are covered, both incremental and more 'transformational'.

Emergent approaches to change admit and accept that far less can be done about managing change than one might suspect in contrast with this planned, rational model. The 'logic' of change under emergent change approaches is based deeply within the forces that determine how individual humans act, personally and as groups. Collectively, these human forces are much harder to circumscribe, least of all pinpoint. Under an approach based on emergent change, change is understood to be a function of context. The managerial rationale of control is viewed as an enigma, fiction and myth by this approach.

These respectively differing aspects are highlighted in Table 2. According to currently popular conception, planned change takes place as a result of purposeful envisioning of a plan followed by overcoming resistance through planned, purposed and rational action. The efficacy of managers to achieve this type of planned enactment of change, leading towards the achievement of envisioned change state, has been popularised over recent years by a proliferation in literature within the management field. The authors of these publications have actively promoted the suggestion that this type of change is both possible and preferable. Its achievement is typically mooted as being made through the conscious elimination or pacification of sources of resistance to proposals of planned change.

On the other hand, emergent change should be regarded as typically unplanned. It has been demonstrated to occur through the interplay of sociological forces between the minutiae - to use Schein's term again - of the organisation (groups or individuals) at the political and interpersonal level within organisations (Weick 1979). In this instance, the immediate historical context should be seen as the most direct and overtly important determinant of the type and outcome of the change process. The interplay of social forces within organisations is the key factor in an analysis of this sort of indirect and unplanned change (Weick 1979). It involves retrospectively making sense of the way that change and action happens. In this Weickian context, sensemaking is best done with people involved in the change and action. This can only occur after the event or action.

The two conceptualisations or approaches to change of the planned and unplanned or emergent variety are expressed in the tabular form that follows:

Table 3

Comparison of planned and emergent change

Change	Process	Method
Planned	Vision enactment process	Reduce resistance
Emergent	Sociological process	Interplay of context

(Based on Wilson 1995)

There can be no doubt that both approaches represent facets of the way that change takes place. Emergent change theory reminds us of the interplay of forces that are beyond the control of individuals and yet created nonetheless by them in the sculpting of history. These forces combine to produce change over time. It is rightly pointed out for today is characterised by many ardent voices proclaiming the ability of people to control the world. This is not always the case.

Planned change theory reflects this purposiveness with which many people believe that they shape their own reality. It reminds us of the ability of people to make decisions and to take actions in creating the world of tomorrow. Whereas emergent theory focuses upon the drivers of change that lie outside of the actual participants within it, planned theory accepts and places these people as the primary forces leading towards change. It focuses upon the ability of the manager to strategically choose change options. The manager is the 'doer' in the change process (Wilson 1995).

As the dominant and more applied perspective upon change, planned change theory is focussed upon in the discourse of this paper. It is appropriate as it esteems what is purposefully done as important in how change occurs and is managed. After all, this tangible and physical world is the only one that we all experience in a verisimilitude manner. We shall return to the debate between these two approaches as they apply to the analysis of change and its management in the case of Canterbury Health Ltd during the parameters of this study.

The management of planned transformational change

Transformations in perception are a central part to successful organisational change. This much seems clear. The creative resolution of conflict and new levels of understanding seem to require such a binding agent. What promotes such binding? I propose (based on Olson 1990) that attempts at organisational transformation need to encapsulate the transcendent and spiritual elements typically found explicated and aimed at being harnessed in team-based, developmental approaches to organisational change. Here, there needs to be a combination of economic rationale and human considerations. Pragmatism requires the balancing of these two ends. In terms of organisational considerations, they can be found at two ends of a continuum. Economic considerations are important from an organisational level of importance and, possibly, at sub-unit business levels. Human considerations are important especially at the group and individual levels of organisational analysis.

Porras and Silvers (1991) view of transformation is typical of what can be said to constitute a traditional or mainstream approach to the preparation and application of planned change, along with a pervasive, business-focussed, academic approach to this topic. There is a conceptual difference between what is suggested here and what is suggested within the framework of this paper. Typically, in the former, the focus upon transformation is based in an economic approach and displayed by significant, apparent change. Envisioning entails more than just setting out to realise material ends. For the purpose of this paper, transformation refers to a broader type of change that captures the holism of the economic-developmental connection towards transformation in a similar way to that which the description of the person being described out of spirit, soul and body describes human life. It certainly includes the act of establishing vision. This much is critical. Vision, yet, must be broad and encompass a full range of organisational experience and dynamic.

Transformation is not just quick, top-down, authoritatively led change. It might be subtle. It might be dramatic. Indeed, it is both. Change is as dramatic, loud and colourful, as it is subtle, soft and obscured. It is not to be found contained within a dominant group's set of appreciations alone. It affects all, envisioners, implementers and recipients alike. Transformation also extends beyond human boundaries. It is demarcated by profound shift. It can happen both fast and slow. It can be both overt and shaded. Here though a point is shared with Porras and Silvers (1990:70): transformation affects "a 'deeper' level in the organisation than those traditionally targeted for change by OD (i.e. work setting variables)". This does not mean that OD

is unimportant but rather underlines its place as a precursor to or starting point for organisational transformation. Transformation, in their words as "second-generation OD", is built on OD.

Conceptual arguments over the essential differences between transformational (discontinuous, frame breaking) and developmental (incremental, adaptive, continuous) change have been well honed over the last decades. The difference is generally clear although distinctions are blurred around the edges of the theory. Arguing over semantics as to what exactly constitutes organisation transformation seems not very productive. Transformation is an abstract notion. Empirical testing can occur upon its manifestation yet the phenomenon itself remains unable to be discretely classified, constrained or measured.

OD typically aims at intra-system realteration, bringing aspects of the system into alignment, fit or congruence (Porras & Silvers 1991). Traditionally, transformative change has been viewed as aiming at a much deeper alteration (Porras & Silvers 1991). However, both can be viewed as being after the same essential thing, namely fundamental change involving the shifting of the focus of people. Both own a 'vision' of sorts. Both work to create new end goals on the basis of a clearly articulated set of humanistic principles and/or values. Both can certainly lead to the same outcome, namely transformation. The chief difference is the respective timeframes involved. OD looks at the long-term and acts on an incremental or adaptive basis. Traditional transformation works on a shorter timeframe, aims for eruptive (rather than adaptive) paradigm shifting, and is less transitional.

Both of these types of change share certain requirements and attributes. Each is reliant upon the importance of purpose, goal and direction. Each implicitly contains a new perspective that questions present organisational assumptions and habits. Each relies on the use of increased energy fields. Each requires high leadership and motivation forces. Each demands performance excellence. This is the implementation component, the end-state of the vision. Each utilises aspects of human empowerment and the creation of an organisational environment within which human potential can be better realised.

A synthesis of this sort appears to underpin the construction of many sets of 'recipe'-like approaches to undertaking organisational change. Formulaic lists of instruction as to the process of implementing strategic change exist in wide abundance (e.g. Kotter 1995, Nadler & Tushman 1989; Beer, Eisenstat & Spector 1990, Nadler & Tushman

1989, Senge 1990, St Leger & Walsworth-Bell 1999). These prescriptions are based on a meshing of both OD and typical 'transformation' approaches. The differences between modernist and post-modernist principles of management seem to follow a highly similar demarcation. The usual transitions within this 'recipes' are as follows:

i.e. vision creation leading to habit-breaking and repeated communication leading to commitment induction and enactment leading to the achievement of desired change goal states

Such prescriptions tend to emphasise two critical aspects of transformation. Firstly, that it is a process and, secondly, that it requires leadership. A five 'C' model of transformation could be broadly said to exist:

1. *C*reate the vision
2. *C*reate the plan
3. *C*ommunicate the vision and the plan
4. *C*ultivate motivated and empowered stakeholders
5. *C*ement change in the organisation's culture

Returning to a discussion of the two approaches to managing change of this paper, a view that transformation is only achieved by non-developmental methods and that only methods labeled 'transformative' uniquely identify these features is hardly a transformative view. In general, both of the described methods fit quite comfortably together on a thematic basis. Paramountly, the values underlying both transformation and development are, at least, roughly similar. Both leadership and performance excellence are emphasised by transformation models. Facilitation and human empowerment are the flipside of these according to OD models.

It is the contention here that, despite what might be problematic by definition, transformation can also be achieved by the fine-tuning methods of OD. Development, in a complementary fashion, can be seen to involve both isomorphic and quantum elements. The quantum element lies in its conceptual nature, requiring large mental shifts if it is to succeed. Isomorphism is its outward appearance. Differences do, of course, exist between generations of OD approaches. On the whole, however, divergence between development and transformation then involves differences in degree rather than essence. Such is the view invoked in the conceptual framework of Table 5.

Neither single perspective towards organisational transformations seems on its own to be enough. The suggestion of this paper's conceptual framework is that they need to be integrated. This is to, in Dunphy and Stace's (1996:554) words, get beyond and "break with one-model models". In many ways, universal models of the management of change are inadequate but they at least provide general guidelines. Specifics are broken down better within contingency-type frameworks. The model of this paper is a universal model, integrative of existing theory. It suggests a synthesis between the traditional OD model, which prescribes incremental change, combined with a participative management style and a variety of other approaches of the more directive genus.

The main contribution of OD is that it has helped focus attention on the social and psychological aspects of change. Individual change is an important part of wider strategic and corporate-level change. OD models had overlooked this and the possibility of technology-led change in the past. So too, management has often overlooked change outside of technical and structural solutions. These precedents now need to change in practice. This need for integrative and holistic approaches to managing change is becoming increasingly acknowledged and the empirical evidence for the value of such approaches, combining human and business dimensions, is building (Worren, Ruddle & Moore 1999).

Bartunek and Louis (1996:97) noted that "organisational development and transformation represent two different approaches to the understanding of organisational change" but argued that the two approaches are compatible and "considered jointly, inform the larger understanding of change". They did not, however, argue for synthesising the two approaches but for continuing to treat both approaches separately maintaining a debate between them. It is here that the framework of this paper both coincides and departs. It is held that the two approaches are certainly compatible but that they should be synthesised and viewed together as complements in the process of achieving organisational change. OD is best applied at the business-unit level of the organisation where consultation can best occur. At the corporate level, non-OD approaches tend to be normative and most practical. The point is that the use of each approach can enhance the other and produce harmony, balance, and productive organisational change for both people and bottom-line results.

The central concept of this sub-section as it relates to OD and organisational transformation – that the end is the same while the process is different – has been

attempted to be borne out in the conceptual framework that is presented in this paper. This framework features in the next section.

Situational considerations in the management of planned change

Existing management literature suggests that deciding between which approach to change is undertaken can and should depend upon a range of factors. For approaches to the subject of organisational change are not restricted to those two mentioned already. The latter are approach conceptualisations for the purpose of this paper. Other approaches that can be seen to exist include behavioural, structural and cultural approaches. This range is based on approaches that have been developed by theorists and practitioners for understanding and explaining organisational change.

Behavioural approaches are largely derived from applied psychological bases, structural approaches from organisational theory (emphasising the interplay of the environment on organisational design e.g. isomorphistic institutionalism), and cultural approaches from sociology and political science.

Forces that promote and negate change exist and operate upon a continuous basis within organisations. Lewinian theory builds on this to suggest that the status quo or a lack of change is the product of balanced, stabilising forces for and against change that act as a counterweight to the other's motivation and purpose. Change can be both viewed in a sense that is either apart from the control of individual actors or as the explicit result of this group's actions. Management approaches typically stress the latter. Sociological theory typically the former. Nonetheless, change should be viewed as being continuously enacted whether by either the deterministic forces of social and economic background or by the conscious and measured approach and effect of people. What creates this environment so conducive to continuous adaptation?

When considering the mix that creates purposeful and observable change, force field analysis offers a realistic framework. This highlights those elements that in the end result lead to changed organisational states. Organisations are in a constant state of flux because people, who alter and wane as well, make them up (Burrell & Morgan 1979). People are dynamic and constantly changing (e.g. in terms of persona, appearance, and past experience). Hence, organisations are dynamic and constantly change too.

The key drivers of change derive from the source that most resistance against change comes, that of people. New people – lower staff personnel or leadership – can provide the impetus for change. Technology can achieve this too. People, however, can be highly obstructive when it comes to implementing change in a planned fashion. This is for a variety of possible reasons. The fear of failure, loss or the unknown can produce inertia or direct hostility. Culture, the product of interactions between a group of people, can also produce resistance to change. Other restraining forces are physical. These might include rigid organisational structure or a lack of resources. They can be psychological – the effect of self-belief, sunk costs, or contractual agreements can have large implications on how people respond, especially in situations of escalating commitment.

As people can be key drivers of change, wider forces can fill this role as well. An example of an emergent, systemic force, that of political ideology, will be used in understanding the current national health system within subsequent sections. Building upon this, the economic climate of a society can, to some degree fatalistically, determine the structure and management of organisations. This can be seen to have applied to New Zealand over the last two decades with the pervasive influence of neo-liberal thinking within common business practice from its usage and implementation in the circle of state policy.

This factor of climate can restrict the way that change occurs in organisations. Elements from the level of state policy can become normative and transmitted through organisations by isomorphistic tendencies. Values from this climate can sink into managerial styles of action and impinge upon or cloud the mental models used by managers to view aspects of organisational purpose and future. Other systemic forces related to society and environment can also drive change.

Both economic and developmental approaches represent approaches toward the management of fundamental organisational change. Aspects based on contingencies, however, cast significant shadows over these models of change. In brief, contingency theory suggests that at one moment some approaches to or styles of are better than others. Managers are constrained by time, cost, and, possibly most considerably, ego. This last concept will be explored in the implication section.

In considering when managers might use one method of approach to change over and above others, Dunphy & Stace's (1993) approach to management style is most pertinent. It is an applied model that seeks to describe appropriate approaches to the

methods that should be used in situations of planned organisational change. It is a normative model based on observed interactions within corporate organisations and its principles make commonsense applications. The key strands to it involve the notions of the degree of change required, the degree of adaptive organisational fit to the environment, the degree of stakeholder support and the degree of available time in which the organisation can take action. Dunphy and Stace conclude that a range of styles should be used depending on the mixture of these factors. These styles and mixtures are linked in the matrix below (Table 4). This approach to planned change shall be explored in connection with Canterbury Health Ltd's approach to change over the last five years in a later section looking at case analysis alone.

The more coercive change strategies suggested by this model are linked to a lack of time amongst other things. This type of strategy shares this in common with economic approaches as they have already been defined within the ambit of this paper. Both seem to be necessitated through the need to make changes or arrest change in the shorter term. The reciprocal can be said for developmental approaches. Again, this has already been outlined in previous sections. A connection then could be proposed to exist between collaborative change strategies and developmental approaches (to such strategies) on the basis of the wider timeframe for change that each can be seen to work within.

Another clear linkage between coercive strategies suggested by this model is with respect to a lack of clear collegial support for the proposed scope of change. Where key interest groups are supportive of change, collaborative approaches to change are enlarged. This aspect, along with the rest of this conceptual framework is tested as a part of the case analysis that follows as change applies to Canterbury Health Ltd.

It is clear from this element of Dunphy and Stace's model that if inter-organisational relations are poor, then the nature of change within the organisation will be likely to be far less collaborative and more coercive. This compares strongly with Worren, Ruddle & Moore's (1999) comments upon programmatic and directive leadership of the change process, built on detailed planning and top-down management, being more appropriate where the destination and change journey are predictable and the time-scale for action short.

On the other hand, a more transformational leadership style is necessary when radical shifts are required in a context of high uncertainty (Worren, Ruddle & Moore 1999). These combined remarks are suggestive of definite implications for human resource

management (HRM) and strategic human resource management (SHRM) in the area of labour relations. Again, this will be explored later in the section of this paper devoted to case analysis.

Table 4

Dunphy and Stace's (1993) contingency approach to change management

QUESTION	YES	NO
1. Is the change based on expansion or reproduction of the present state (as opposed to fundamental alteration of the present state)?	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)
2. Is their support for change from critical interest groups?	Collaborate	Coerce
3. Is the organisation in fit with its environment?	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)
4. Is their much time available?	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)	Collaborate (if supported by key interest groups) Coerce (if not supported by key interest groups)

In an earlier piece of work (1990), Dunphy and Stace expand on the styles of change leadership that are implicit in these two broad bands of collaborative and coercive leadership type. They expand on these end-types of collaboration and coercion by introducing intermediate descriptors of consultation and directiveness, linked to collaboration and coercion respectively. They define collaboration as involving widespread participation by employees in important decision-making. Consultation comprises a more limited involvement of employees in the process of goal setting. This involvement is seen as being only relevant to their area of expertise or

responsibility. Directiveness involves the use of managerial authority and direction as the main form of decision-making about organisational future and change. The use of senior executive or external force and imposition of change define coercion.

Their 1993 work describes these types in the following terms respectively: participative evolution and charismatic transformation (for styles of collaborative and consultative change management) and forced evolution and dictatorial transformation (for styles of directive and coercive change management). They refer to styles of change leadership across a wide scale of change size. These types can be referred to as Type I (collaborative), Type II (consultative), Type III (directive) and Type IV (coercive).

CONCEPTUAL FRAMEWORK

Economics has the tendency to analyse all human action through the screen of tangible cost and reward. In this section, the weaknesses of such an approach to organisational affairs is critiqued and an integrated perspective on the analysis of the management of change is suggested, involving but not being restricted by this 'economic' view. A framework that looks to synthesise both economic and developmental approaches to the management of change is presented. These two perspectives appear integrated best upon the basis of the notion of 'trust'. It is suggested that trust remains the 'glue' in this integration. In practice, this mix implies acting pragmatically.

A synthesis of economic and developmental approaches for the analysis of the management of planned change

A key criticism of positivist agency theory is that it understates the contextual determinants of performance "by failing to partition the uncertainty created by interdependence with other individuals from truly random events" (Nilakant 1994:45). Contextual random elements play a significantly greater part in the production of individual performance. "Moreover, the assumption made by agency theorists that only one of the parties directly influences the probability distribution of the outcome is untenable because of the variations in the degree of control exercised by agents over the random elements facing them and the influence wielded by principals over the random elements confronting the agents responsible to them (Nilakant 1994:45)"

Too 'economic' an approach to an organisation's operation can therefore be deleterious to a proper understanding of events. It omits contextual factors and fails to consider the individual from the perspective of interdependent relations. An economic view alone is sterile and raises the ire of those with a more anthropologically minded view of human existence. Approaches based exclusively on economic models may not only be simplistic but may actually exacerbate the problem by ignoring facilitative effort (Nilakant 1994). Solutions are to be found through increased interaction and joint learning, this being the type of effort that is missing from formal economic models (Nilakant 1994). In the area of health, a high degree of interdependence takes place. They are complex human networks and operational effort does not occur nearly so much as facilitative effort due to the dynamic nature of health's work environment (Nilakant 1994). Managerial health work is characterised by variation, contingency, choice, negotiation, pressure and conflict, thus the health context does not require a

simplistic model of an economic approach to change. An integrated, operational and facilitative model is needed. Meshing and partnering an economic approach with a developmental approach provides this. Roberts and Dietrich (1999) discuss why economics needs this sociological influence within its discipline.

Roberts and Dietrich's (1999) main argument is that economics provides a partial but insufficient analysis of organisational life. They suggest that economics needs sociology to provide an effective conceptualization of both organisational and individual modes of behavior. Reinforcing the point that both perspectives are needed in an appropriately measured view of life, however, they equally infer that sociology needs economics, for "while the sociological context provides an explanation of the way power is institutionalized, an economic focus is necessary to maintain a role for individual agency" (1999: 998).

Khalil (1999) points out how organisations can be viewed as either market structures, networks and associations, or as organisms and ecosystems. He states that while both kinds are spontaneous (that is, not artificial or designed by an external agency) they differ in one important aspect. While structures express efficient arrangement given the constraining variables, organisations involve political constitutions expressing coherent individuality whose nature is not premised on efficiency considerations. The dichotomy sheds light on the difference between market dynamics and organisation development.

This divergence is the central thread of the framework that this paper explores organisational change through or with. The implications of this paper also follow the direction of the conclusions of Davis, Schoorman & Donaldson (1997) with respect to combining a view of management from both the alternative fields, upon the study of people, of economics and human science. Their thinking tends towards a 'stewardship' theory of management.

Such a view accepts that economic approaches to governance tend to assume some form of homo-economicus, which depict subordinates as individualistic, opportunistic, and self-serving (Davis, Schoorman & Donaldson 1997). Alternatively, sociological and psychological approaches to governance such as stewardship theory depict subordinates as collectivists, pro-organisational, and trustworthy. They reconcile the differences between these assumptions by proposing a model based on the subordinate's psychological attributes and the organisation's situational characteristics. This chief implication is mirrored within the results of this paper.

The individual utility maximization assumption of economics only reaches so far in a real world analysis of people (Noordhaven 1992). Perrow (1986) states that the central assumption of agency theory, the assumption of individual utility maximization can, at best, partially explain human behaviour, and that agency theory should make clear under which circumstances individual utility maximization may be assumed and under which circumstances other, possibly conflicting goals have to be considered.

Likewise, Etzioni (1975) postulates a dual human nature, with aspiration to individual utility and compliance with moral imperatives as constituent elements. Donaldson (1990) points at the narrow account of human motivation offered by economic organisation theorists, and proposes an alternative view of organisation members acting in the interest of the organisation as a whole, rather than driven by self-interest. Agency theorists choose to concentrate on the exertion of choice rather than on contextual restrictions.

In a well-balanced analysis, attention should be paid to the constraints to choice as well as to the exertion of choice within these constraints and attempts to change them (Noordhaven 1992). Analytical attention also needs to be paid to the place that, both personal and institutional, trust holds in organisational arrangements. This is what the organisational development literature has been widely recognised for providing for private and public organisations (Golembiewski 1989; Carnevale 1995). The central place of trust in planned change remains a feature of the framework of this paper.

On one side, several scholars have stressed the criticality of building trust rather than manipulating the contextual environment with incentives and monitoring (Ghoshal and Insead 1996; Perrow 1986). In contrast, other scholars prefer the rational analysis of risk in order to alter individual payoffs and, therefore, be able to study calculative cooperation, independent of personal trust (Williamson 1991). This division resembles the decades-old controversy about the nature of the human being such as the classical dichotomy suggested by McGregor's (1960) Theory X versus Theory Y. However, a few scholars have been able to merge economic theories with concepts drawn from sociology (Ouchi 1978).

These authors highlight the role of trust within relationships e.g., the effects of socialization and familiarity. Along similar lines, Davis, Schoorman, and Donaldson (1997) take a more moderate approach by identifying under what circumstances Agency Theory would be more descriptive than a trust-based stewardship approach

and vice versa. It is conceivable that some people may consider trust as 'noise' in rational decision-making that should be avoided (e.g. Williamson 1991). However, when objective information is lacking, people may only use the subjective evaluations of other people's attitudes, competencies, and future behavior as basis for their decision processes. As one of the managers in this study said: "When there are no figures, all decisions are based on trust." Trust underpins human relationships and organisational successes.

It is proposed that the framework presented conceptualises planned change in an integrated fashion. It is a model for planned change. Both it and a model for emergent change based on the interplay of contextual forces will be used in the analysis of the case of Canterbury Health Ltd's management of change.

The essence of change management should be whole system transformation. Table 4 describes whole system transformation as 'deep' system transformation. This is based upon Porras & Silvers (1991) description of organisational transformation. To this point, two approaches to the management of organisational change have been developed and explicated. These are now going to be fused together into an integrative framework. I propose that the intervention methods used by managers in practice in the management of organisational change should utilise both of these approaches for the intention of successful change intervention. Table 4 is based on this notion and provides the conceptual framework in which organisational change within Canterbury Health Ltd 1996-2000 will be strained and analysed.

The key idea here is that both the human emphasis of OD and the rational economic emphasis of standard cost management need to be brought together in a holistic manner to provide a point of pragmatic social-financial balance in terms of the outcome of change interventions within organisations. Worren, Ruddle & Moore (1999) support and develop the central idea of this framework in relation to the scope and nature of the management of change. They assert that, through the emerging field of change management, a reaction to the bounded and single-lensed approach to the management of change is being pronounced. It is the plan of this framework to expand upon this point and provide a dual set of sense, a multi-lens, through which to appreciate how change can be accomplished.

Both the aspects of OD and the rational economic emphasis of standard cost management, as already discussed, provide linear approaches to the subject of how organisational change can be achieved and measured. Neither is wholly sufficient in

itself, however, and this is the realisation that Worren, Ruddle & Moore (1999) bring to bear. One approaches the organisational setting and the topic of change from the perspective of the lay participant. OD does not pretend to do otherwise. The other pinpoints variables far more from the perspective of senior ownership and management. This detachment and responsibility is now accepted from management throughout the Western world. Indeed, management has become reified as a profession in this world because of these mutual qualities of imposition and privilege.

Worren, Ruddle & Moore (1999:281) make the point that neither is wholly sufficient in itself. They state that "both the world of business and the world of human relationships" needs to be understood, and understood at the same time and within the same context, namely that of the world of business organisations. Previous to the last decade, in which this concept of organisational 'change management' has emerged, both of these separate approaches to organisational change were viewed all too often as linear, step-by-step, sure-fire and stand-alone methods. This, with the benefit of hindsight, is clearly not the case. A comprehensive approach to change needs to cut across traditional change theories, such as those of socio-technical systems change (with its attendant internal, system focus) and strategic change (with its external, output focus).

People are increasingly being recognised as possessing huge importance in the change process. The importance of this human side of business change is well-reported (Worren, Ruddle & Moore 1999). The management of change involves two faces, then. That of human performance is at the core of business performance. That of profit delivery is the other key objective of change.

There are, of course, difficulties associated with an integrative approach to managing change. Worren, Ruddle & Moore (1999) describe these in terms of the concepts of task integration and change navigation. Task integration refers to creating congruence between strategic human and business process perspectives. "Integration and alignment between strategic, social and technical components require collaboration between people possessing skills in different areas. However, such collaboration is often difficult (Worren, Ruddle & Moore 1999:281)."

A second major challenge is change navigation. Change navigation refers to the implementing of change by interventions aimed simultaneously at multiple components of the organisation. It involves monitoring this process this over time and it is a process that can require quite opposite methods at differing moments. The

sequencing of interventions can be a difficult process, especially when trying to address the issue of culture change as an intended by-product of business-orientated change. When to introduce changes in formal structure becomes a question of timing and context. "As the change program unfolds, the context may also change, creating the need for continuous adaptations. It is often difficult to strike the right balance between top-down direction on one hand and participation, empowerment, and flexibility on the other (Worren, Ruddle & Moore 1999:282)".

The management of change needs to encompass both approaches, both coming at the problem of change as they do from very typically different directions. OD is an 'inside-out' process effectively, starting at the group-level and working outwards until culture is permeated. Standard economic management is typically 'top-down' and infused through an organisation by means of a combination of soft, joint involvement of the recipients of change and, at times, a needed hard-edge of direction and enforcement. Both are certainly required at times. Both can be means to the end of a transformed organisation. As Gary Hamel (1995:9) has said, "transformational change can be revolutionary in outcome yet evolutionary in execution".

What is more, change management will certainly be better validated and more useful when it recognises and makes use of both these approaches. This might even then lead to the development of both a more all-embracing and widely-accepted theory and practice in organisational change, or, at least, better agreed guidelines for action by change agents that is less affected by fad and better wrested in truly holistic results involving both the lives of people and bottom-line gain. Theory is necessarily infused with ideology. This type of theory is influenced by a social ideology that strives to hold social and material results in tandem within the assessment of the results, costs and benefits of organisational change.

In short then, the implication of this conceptual framework is that entire or holistic transformation through change management is only possible when both structural transformation (economic) and cultural transformation (developmental) occur in tandem or in a fused manner.

Table 5

ASPECTS OF PLANNED CHANGE MANAGEMENT IN TOTAL CHANGE MANAGEMENT

Process	Broad management approach	Primary goal characteristic	Output measurement unit	End
Work-level, group-based (Inside-out) change	Organisation DEVELOPMENT	Learning TRUST	Intangibles PEOPLE	Transformation of OPERATIONS
Corporate-level (Top-down) change	ECONOMIC Revitalisation	Efficiency BOTTOM-LINE	Tangibles PROFIT	Transformation of BUSINESS UNITS
Complete planned strategic (Core-periphery) change	Trust-based (developmental) Fundamental, deep system (economic) TRANSFORMATION	Values SOUL	Total results HOLISTIC	Transformation of ORGANISATIONS

METHODOLOGICAL FRAMEWORK

This section contains a statement of the research framework and techniques employed for this paper.

Several social scientists have suggested that increased attention be given to the study of everyday life activities in naturally occurring settings. Karl Weick links this suggestion with the utilisation of innovation in the process of crafting organisation theory (Gephart, in Van Maanen (ed.) 1998; Weick 1979). Case studies are a particularly useful way of achieving both the objectives of studying everyday activity and producing organisational theory, as they apply to natural settings, because of the way in which case study analysis provokes the examination of ordinary activity using multiple theoretical implications (Bryman 1992). This can be combined within a single study, thus providing a mix of representation and interpretation of everyday life in an unfolding history and it is precisely this end that this particular study attempts to produce.

The overall aim of this study is to improve our understanding of the management of change and, in particular, the problems associated with this management when dealing with change in the health sector. It proposes to build upon the existing literature on the management of change through a detailed study of the management of strategic change in one specific hospital and health service organisation. Through this it aims to provide useful guidelines and applications to managers and theorists alike.

In this sense, this study is strongly in sympathy with the views of Henry Mintzberg when he writes that his aim is to "present theory that is 'grounded' - that is rooted in data, that grows inductively out of systematic investigation of how organisations behave. I am firmly convinced that the best route to more effective policy making is better knowledge in the mind of the practitioner of the world he or she actually faces. This means that I take my role as researcher and writer, like Mintzberg, to be "the generation and dissemination of the best *descriptive* theory possible". I believe it is the job of the practitioner to prescribe, to find better approaches to policy making. In other words, I believe that "the best description comes from the application of conceptual knowledge about a phenomenon *in a specific and familiar context.* Good descriptive theory in the right hands is a prescriptive tool, perhaps the most powerful one we have" (Mintzberg 1979:vi). My concern is, therefore, to develop a grounded theory of organisational management of change.

This study concentrates on the four chief institutions of Canterbury Health Ltd. Out of these, one organisation dominates, that of Christchurch Hospital. It does this not just because it is far and away the largest but because it has been the focal point of many of the wider change issues in which the strategic or corporate level of Canterbury Health Ltd has been involved and made decisions regarding change upon. The experience of Christchurch Hospital certainly well represents many of the facets of the change process that this thesis will focus upon in its implications section. This hospital is the biggest in the Canterbury Health Ltd catchment area and also represents particularly well the nascent power and management structures of the broader Canterbury Health Ltd region under the CEO. The CEO's approach to management since 1996 has both affected the HHS's management of change at its nadir and zenith.

The aim of this study was to get as close as possible to understanding how Canterbury Health Ltd's HHS's managers cope with and manage change. Gaining this understanding was done in the main by letting the respondents talk at length for different periods of time about the problems related to change that the organisation faced and how it was coping with them. This was done using a semi-structured interview guide comprised of potential open-ended questions that could be explored in interview time. Part of this objective entailed gaining reliable information from both clinical and management perspectives about the nature of change in Canterbury Health Ltd over the years 1996-2000.

The issue of perspective is highly important. The process and implementation of change is rarely unilaterally perceived. The parties involved in change receive it in personal, hence potentially different, ways. Change is therefore not experienced the same by all. Indeed, from the strategist (who is concerned about the connection between the organisation and the environment), to the implementer (who is responsible for the microdynamics of the change effort, it's internal organisational structure and coordination of elements), to the recipient who traditionally is most strongly affected by the change (since, typically, they have not participated in either the conception or implementation of the change), a wide gamut of experience and perception is broached. In Canterbury Health Ltd's context, it was assumed from the outset that the strategists were likely to reside at board and executive level, the implementers at management levels responsible only for execution, and the recipients at a range of levels largely clinician, nursing and public. This latter group, in particular, feel the effect of change undiluted (Jick 1993). This study aims at uncovering these perspectives and whether or not these assumptions hold firm.

On this basis, the study was able to analyse elements of change that had taken place in the organisation over time and check this against how different managers understood them and explained them. This, supplemented by extensive secondary data search, in order to set out the chronology of change in the organisation, provided a rich basis on which to understand and describe the processes of management. For the reason, all of the three levels of analysis (individual respondents within health and hospital services, groups e.g. clinicians or management, and the organisation as a cultural 'whole') were tried to be focussed upon. All of these actors or agents were a part of the 'mix' that represented the content basis for interviews.

It is not claimed that the picture is perfect. However, it is claimed that it gives a great deal fuller an understanding of the processes of management over many years in an organisation than might be obtained by causal observation or by survey techniques scanning necessarily more superficial across numerous organisations. It is not suggested that this one organisation, or the managers in it, are representative of all organisations or all managers. Indeed the nature of the context of the study and the limitations this places on the generalisability of the data are explicitly discussed elsewhere. Its general lessons, nonetheless, might well be applicable many other management situations.

Rather, the aims of the study are, first, to examine in as live and real a situation as possible the relevance of existing understanding of the processes of the management of change (strategic or otherwise). In this sense the study is concerned with understanding the relevance of existing theory. A second aim is to generate some theoretical propositions that advance theory, and that others might critically examine, develop, test or simply find useful. There is no attempt to suggest that this study proves anything as such. It is not essentially concerned with theory testing.

The research design for this proposal is qualitative. The purpose of this research, as already mentioned, is to generate new insights into organisational change practices in the health sector, which are useful for building theory. This was facilitated by observing and speaking to people within four different institutions in Canterbury Health. These four points of observation at an empirical level were used to craft theory at the conceptual-abstract level. The aim was concerned less with establishing connections between variables and more with understanding the experiences, as they relate to change management, of individuals, groups and institutions at the

organisational level in the specific cases analysed. The emphasis of this research was from the perspective of the inside, looking out.

Before the nature of these reforms is discussed, it needs to be clear if it is not already that it is the impact of change on human systems that is the focal point of this thesis. These systems involve patients, medical staff, health management and the public alike. Organisations are made up of these systems. They are the single uniting factor between organisations. People are this characteristic. Perhaps also reflecting a latent and genuine human resources management bias, it is proposed that the impact on management of the reforms of the last seven to eight years is best studied and, indeed, understood using the approach afforded (and methodologically best underpinned in this instance) by the ethnographic inquiry of a case study research method with its associated research tools composed largely of observation and unstructured interview.

Some of course will disagree with this. It is the contention of the author that the subject under study is an essentially anthropological one involving people as the core element. Health is a service industry and cannot escape being otherwise despite the manner by which numbers, in an accounting sense, and not people have become the greatest focus of New Zealand's current health system. For this reason the quantitative analysis of numbers will be used in this paper only in situations where they better describe the situation of what has happened in change management better than the responses of the people involved.

Data collection

Anecdotal evidence was collected from people across a wide range of people involved in the health services across the Canterbury region. As already mentioned, however, a major source of information for this study derived from face-to-face interviews with key respondents from the field of organisational change within Canterbury Health Ltd over the last five years. Approximately 44% (7/16) of this group were senior members of the clinical, medical (largely clinical directors) and nursing fields in Christchurch or groups sensitive to these fields e.g. unions and the media. The rest of these respondents were drawn from a variety of management or human resource management positions from board to advisory levels within Canterbury Health Ltd. This majority group formed approximately 56% (9/16).

Discussion with internal health sources in the production of this paper was wide and disparate. Medical consultants, departmental heads, general managers, medical advisors, human resource specialists, management consultants, chief or ex-chief executives, clinical directors, surgeons, secretaries, nursing staff, board members, members of management in functional areas, reporters, and union representatives were all spoken to in the course of researching this paper.

Internal sources for respondent interviews came from HHS staff in both corporate and line management in Canterbury Health Ltd. From these, views on the CEO's management from within Canterbury Health Ltd were exacted. Interviews included those of face-to-face semi-structured and telephone natures. Other internal information was provided by documents from inner sources, e.g. public documents, financial reports, public relations material, communications office material, staff newsletters, broadsheets, memos, material on HRM policy, along with health publications from other government sources.

The aim and reason for speaking to this mix of people revolved around answering the key question of this paper: what is the approach to organisational change that has been characteristic of the style adopted by the management within Canterbury Health Ltd over the last five years? This involved examining how change has been managed within this institution within this period. In the practice of interviews, this question was broken down to explore exactly what has changed in this institution of the period, what the CEO was instrumental in changing and what has emerged in an unplanned sense within this period, how change has been made and how challenges to making change have been overcome.

External sources of information comprised respondent interviews with the media and other outside commentators, including the input of a senior business consultant. As already mentioned, documentation from external sources was used. News extracts and Health Funding Authority and Ministry of Health publications were relied upon. Also, to help embellish the collection of data, I even considered and made enquiries about the opportunity to become an orderly within Canterbury Health Ltd but to no avail. This did not result in my being able to procure such a position.

In all these methods of data collection, a qualitative research design provided the framework and basis upon which data was collected and analysed. The investigation's orientation remained firmly on the perspective and responses of the respondents, using the powers of observation, interview and archival scrutiny with a view to

understanding how actions and events happened from the outlook of the insider. Within this framework interviews were used as the primary focussing tool, generating probes within and revisits to the subject.

A social constructionist view of reality forms the underpinning for this paper. Utilising interviews as the primary method for collecting the evidence required has both strengths and weaknesses (Yin 1994). Bias can creep in due to poorly constructed questions and through both interviewer and interviewee responses based on perceptual selectivity or reflexivity, on the part of the interviewee. Within this research values of all parties have been tried to be accepted. From observation to conclusion, inductive reasoning was used, culminating in the triangulation of data sources. The unit of analysis of this study was the organisation as a whole. Within this, prominent persons and groups of individuals such as managers and clinicians were conjointly considered.

In terms of ethical consideration, agreement was reached with all respondents for the research as to the anonymity of their input for reporting's purposes. Subject to their not being named, both in connection with quotations or generally, the informed consent of this group was granted.

Data analysis

Thematic analysis is attempted within the later sections of this paper on the basis of topical sub-headings that the author felt were appropriate. Idiosyncratic or not, these sub-headings were drawn from topics and issues that arose from the depths of discussions held with the key respondents in this study. They were repeated ideas. Hence, they naturally appeared to be important and were focussed upon as key in the discussion of implications that these later sections form.

The significance of this study's analysis is simultaneously both limited and wide. As a case study, some generalisability may be able to be made. To this end, the implications that this study draws are broadly relevant to all health and hospital services within similar global health systems. In some matters, its implications apply to all points within this sector due to the generality of the comments upon these implications. The relevance of these implications will however depend on the context of the individual institution. Some specifics relate to the context of Canterbury Health Ltd alone. It is a matter for the reader to distinguish between where implications are

relevant and where they do not apply. As the colloquial expression renders this point, if the cap fits then so it should be worn and accepted.

> So socialism causes rudeness. And capitalism causes rudeness. But if you go to Sweden, where they've got both, everybody's polite. You figure it out.
>
> O'Rourke, P.J., *Eat The Rich* (1998), 139

> To change and to improve are two different things.
>
> German proverb

PART II A CONTEXT FOR EXAMINING MANAGEMENT OF CHANGE

THE CASE OF CANTERBURY HEALTH LTD (1996-2000)

A section based on the history of Canterbury Health Ltd. This section sets out to lay the scene for the case analysis that follows it. In order to better understand the context that Canterbury Health Ltd operates within, the disparate perspectives of the participants in the national health context need to be detailed. This section variously considers the politicians, the managers, and the clinicians involved in creating and managing the change that has occurred within Canterbury Health Ltd over the last decade and attempts, to a degree, to view this change through their lenses.

From the outside, it appears that successful change has occurred within Canterbury Health Ltd over the last five years and that, generally speaking, the organisation under the guidance of its management has evolved favourably over this half-decade. Bottom-line results have improved. Numbers of people being attended to have increased. Funding has increased. In 2000, Canterbury Health Ltd appears to be a stable organisation entering a new phase of its history as it contemplates a merger with Healthlink South and life under a new political regime. Coupled with the return to the Area Health Board model and an almost certain shift in staff, further and possibly 'deep' organisational change is upon the near horizon.

Planned change and the public health system have been regularly connected over recent times. Health and education are often the best public faces of a society. The continuous change within health services and health planning over the last two decades (as in education) has both demonstrated and signalled the wider change and dynamism that has increased within society as a whole in that time. Precursors to

health system formation, namely those influences of the global environment and national politics, have changed and sometimes changed radically and quickly in this time.

To appropriately understand the nature of the success that has taken place within Canterbury Health Ltd, however, the context that this organisation was in by 1996 needs to set out. This context is both of a macro (political) and micro (institutional) sort. For, primarily upon events that occurred at Christchurch Hospital between its clinicians and the organisational board of directors and driven by reforms that had been introduced at the highest national level, Canterbury Health Ltd had become a highly dysfunctional organisation by the stage that The CEO took over in the final months of 1995. The preceding months were truly a 'winter of discontent' and the ramifications of these months had meant that crisis management was well required by the incoming chief executive.

The macropolitics of change: Canterbury Health Ltd's external environment

> *If you go back to the commercial model of the CHE, the pressures were quite interesting and this is my surmise of what is going on as much as I can tell. When [an earlier manager] came in ... we were beginning to work together as a management-clinical team, until the fateful day when they announced the restructuring of Christchurch Hospital in terms of the nursing structure ... and everything changed in that sense overnight and without any ... consultation ... It sort of ignited an opposition amongst aggrieved clinicians who suddenly saw more of that structure that we had built up and had some ownership of just being ripped out ... and that was seen ... as interfering with the qualification of care ... The ... good relationships that we had between clinicians and managers was not acceptable in management's eyes because you needed healthy tension. How could you actually effect change when everyone was being friendly to each other? So the pressure came down through [one manager], the real bastard ... on to [another manager] to do the same ... so he hung in and put it through and then it all went to hell ... I don't think he was doing it to stuff it up. He was doing it because he [felt he] had to do it ...*
>
> *Clinician respondent, 2000*

Over the last decade the health sector has been characterised by dramatic and often unpopular exercises in restructuring that has affected technical and human management systems alike in this sector. Indeed, many groups have damned the resulting system of these health reforms as possessing many intrinsic flaws. The fundamental changes that have taken place within the public health system over the

last decade were not primarily initiated by but, it could be said, have come to be symbolised by the 1993 health reforms. These reforms were built upon over two consecutive periods in power by a widely recognised coalition of right-wing parties, both political and business.

In the early 1990's significant reforms took place within the health sector in New Zealand at a rapid pace (Malcolm 1995). These reforms most important policy reports were those of the Green and White Paper characterised by their associated focus on non-human elements involved in the service and delivery of health care, such as those of costing and budgeting. Scott and Gorringe (1989) describe the focus of these reforms as the enhancement of incentives for performance. The reforms were explicitly focussed on economic aims and objectives. The 'economic' approach already discussed touches on many of the elements that were present as bases to these reforms.

Driving the reforms was the Government's market-oriented philosophy and a declared aim to reduce state spending and lower the proportion of GDP accounted for by government and quasi-government agencies. A symbol of these reforms was concomitantly signalled by the development of the importance of new accounting and information systems (Alam & Lawrence 1994). Admittedly these were begun under the Area Health Board structure of a preceding era. Nonetheless, these alterations continued the demand for a new accountability with the commercial and economic flavour of state ideology being made specific in the practices overtly infused by accounting principles. Through the reforms the activities of the core public sector were separated from the trading activities of government (Scott & Gorringe 1989). These latter activities were constituted as state-owned enterprises with explicitly commercial objectives.

They were put on an equal basis with firms in the private sector and required to act in exactly the same manner with respect to taxation, the general legal environment, raising capital and supplier/customer choice (Scott & Gorringe 1989). A major expectation was that they earn a commercial return on the business equity bequeathed to them by government. In terms of the enhancement of incentives for performance, four central features characterised these reforms (Scott & Gorringe 1989). Contestibly, the most important of these were greater responsibility for departmental heads coupled with greater rewards and penalties, an emphasis on specification of outputs, and the introduction of information systems to help assess performance. These also are very

similar to aspects of the economic approach to change management that have already been raised.

Significant reforms in the health sector in New Zealand had begun well before 1996 (Buchan 1993). However, this year had epitomised as well as any that had come before it all that was negative about a period of retraction in the New Zealand health system that had started at the beginning of the decade. By the end of 1995, hospitals had closed and health services had been cut back, up and down the country. The number of available beds in public hospitals had dropped by nearly one thousand in number since crown health enterprises were set up two and a half years prior. Change had not occurred quietly. The amount of public outcry and antagonism that these changes had caused was building up to a flashpoint.

In the early 1990's, significant reforms had taken place within the health sector in New Zealand and at a rapid pace (Malcolm 1995). These reforms were characterised by their associated focus on non-human elements involved in the service and delivery of health care, such as costing, budgeting, and quality. The emphasis on such things was a tocsin for the broader change that had begun in the mentality of mainstream organisational management.

This business or economic mindset in health-care delivery has paved the way to running hospitals commercially. Accounting has now come to be seen as a neutral technique to pursue economic efficiency with rational calculation of costs of providing services. Up until this time the language and practices of these systems had seldom dominated decision-making in the health care services, however the effectiveness of these rearrangements appeared to require a large-scale investment in such systems. The aim of these reforms was to change the culture of health-care providers. While progress (to some degree of the definition of the word) since this time has been considerable, and in some cases remarkable, problems of implementation and change of organisational culture remain.

From July 1993, Crown health enterprises (CHEs) were legally required to operate as successful businesses in a newly created (pseudo) marketplace (Barnett & Malcolm 1997). These involve extensive organisational rearrangements. The move towards a commercialized, economically driven, health sector in New Zealand was characterised by accounting change for accounting provides a specificity to conceptions of the economic which enable it to infuse and change organisational and social affairs (Manzur & Lawrence 1994). Prior to 1993, the language and practice of accounting

had only rarely infused managerial and clinician deliberations and decisions. Thus, the reforms in New Zealand aimed to change the culture of health-care providers by introducing new accounting and budgeting methods. The legislators set out and wanted to avoid provider capture. In colloquial practice, they didn't want too many doctors or nurses interfering with the overall plan of health management because they were too involved with the system and therefore, it was assumed, inherently biased.

Traditionally, health services were provided in New Zealand in accordance with need. With a gradual worsening economic situation and a decline in economic indicators during the 1970s, there arose an increasing concern with the role of Government in the provision of public services. Concern over funding and overall efficiency in the health sector initiated several studies. While problems in the health system suggested the need for some changes in the institutional framework, the direction of change was motivated by the Government's ideological shift to economic market mechanisms. The Gibbs report (1988) succeeded in focusing attention both on the institutional arrangements of health-care delivery and on hospital efficiency. The report argued, "what is more important, it has to do with the inability of the present system to react to changes in preferences and the difficulty it has in moving resources around".

The previous system was alleged to be inefficient as it could not establish proper accountability systems. Resource allocation and accountability were focused on budget allocation based on identifying and tracing inputs. Accountability was seen as compliance with legal and administrative procedures. The Gibbs report specifically questioned the inefficiencies of health-care delivery concerning poor management performance, lack of management information, and the need to create competitive tendering for health. Subsequent changes in the health sector reflected such concerns by initiating major changes in the institutional forms.

At the highest level of abstraction, the economic relationships in this new model for the delivery of national public health care can be distilled into three distinct nexuses (Reinhardt 1989). The first of these nexuses refers to what is known in jargon as the 'funder-provider split'. In this nexus, the third party funder of the government (or private contractor) transfers money to health and hospital service providers under a variety of distinct compensation methods based on fees or global budgets. In the second of these relationships, health services and supplies are transferred from individual providers of health care to individual patients. Together these nexuses represent aspects of what economists call the 'market' for health care service and supplies. The last of these associations is found in a third party payer, either a private

insurance carrier or the government, shouldering the financial risks of illness that the patient would otherwise face. This shouldering of burden is done on the basis of the receipt of taxes or premiums.

Some critics have pointed out that the Government's 'real' motive in producing these reforms was to reduce health spending either by reducing cost or by shifting some of the burden to users (Charlton & Charlton 1993). The apparent contradiction in reducing the cost of health-care delivery while providing sufficient services was to be resolved by more efficient use of resources. It was proposed by the Government's policy document that resources could be better used through a system of managed competition. These reforms involved the abolition of 14 area health boards (AHBs), the creation of four regional health authorities (RHAs), and the creation of 23 Crown health enterprises (CHEs).

As a result of these changes, health system change became a much-maligned topic of conversation in New Zealand. Sarcasm became noticeable as the recognition that the delivery of health care was ineffective and inefficient and the product of the perverse incentives inherent within it grew widespread. Pim Borren and Alan Maynard (1995) cynically coined a phrase as they looked ahead to what they described as the next 'redisorganisation' of the national health care system.

The funder-provider split and a new health model

The system changed from one of area health boards to that made up of Crown Health Enterprises and a competitive health model whereby these enterprises had to make a profit in order to warrant survival and government support. This systemic change brought with it a significant symbolic and cultural change in the form and through the actions of professional managers, representing a broad and sweeping approach to organisational performance dominated by commercial ideology.

Management culture was really quite diverse and distinct from that of clinicians. Management was perceived to be introducing a corporate model from behind the scenes that bore little resemblance to the traditional way that health services were delivered. There were certainly some excesses on the part of management in terms of spending, in terms of upgrading corporate offices, office blocks, information systems, all sorts of things. And really clinical staff felt that there was no benefit permeating down to the patients. Against this backdrop there was major antagonism. Management was ruled by ruling by edict and autocratic methods rather than being consultative and

including senior staff in-groups or boards and so consequently things really came to a head in the mid-90's. And this really culminated in CHMSA (Canterbury Health Medical Staff Association) requesting essentially an audit of how Canterbury Health Ltd was running and that resulted in the Stent Report. Some of the findings within this report were pretty serious problems identified. Following that, The CEO came in. When he arrived his management style was very different to that of his predecessor.

Under the old system, the health budget of the Government was allocated to fourteen AHBs on the basis of population with some adjustments for demographic factors. The AHBs used to own facilities and hospitals to provide services to their locality. The Ministry of Health used to manage other health-related services through separate contracts with other voluntary organisations such as the Plunket Society (pre-school nursing service). The new systems introduced organisational arrangements by replacing AHBs with RHAs. The RHAs are responsible for establishing health needs and purchasing services for their communities from the providers of health care. This separation of purchaser-provider is supposed to bring efficiency and greater flexibility. The system also separates social and business roles of different institutions.

All the facilities of AHBs were transformed into CHEs. The CHEs will now own hospitals and compete for contracts from the RHA. CHEs are now required to operate as commercial organisations and compete for services that the RHAs demand. Instead of fragmented funding through the Ministry of Health, the new system now channels all funding through the RHAs (Barnett & Malcolm 1997).

These general management reforms generated a paradigm shift in national HHS operations. They were attendant with a 'managerial' ideology of the corporate sector that stemmed from United States models (Malcolm 1995; Greenwood & Lachman 1996). Out went consensus management by professionals, in came business-like managerial hierarchies. This was underpinned by the notion that professionals should be subject to same kinds of accountability and control as are found in contemporary business hierarchies. This could be construed as an attack on these professionals professional autonomy (St Leger & Walsworth-Bell 1999).

The separation of purchasing and providing roles between purchasers (health authorities) and providers (HHS's) led to new tensions between what was perceived as bureaucratic impediment to professional delivery of service (St Leger & Walsworth-Bell 1999). It reinforced the new managerialism, substantially increasing the pressure to replace consensus management with business-like hierarchies. The 'business' of

healthcare become more the 'healthcare' of business. 'Processing people' marked this new paradigm (St Leger & Walsworth-Bell 1999). So, New Zealand health operations have increasingly came to resemble those of the American health system in terms of cost, user-friendliness, and equity (Kelsey 1995) and budgets became a means of organisational transformation (Jacobs 1995). Nurses became patient care managers. Accountants acted as active agents contributing to change. The shit, that was 'the great experiment' (Lawrence, Alam & Lowe 1994), was about to hit the fan.

Dannin (1997) and Kelsey (1995) are not untypical of social commentators in their view of social transformation within New Zealand since 1984. Dannin (1997) asserts that the experience of this country can indeed be read as a heuristic device to understand events in most developed countries during this time. The reasons that led to the introduction of these reforms and to a degree do much to maintain them revolve around ideology. This ideology can be variously described as being New Right, Reaganomics, Rogernomics, and Thatcherism or from the house of the Chicago School of economics. Each refers to a program of liberalisation that focuses upon the commodification of intangibles.

So much for the dogma that surrounded Canterbury Health Ltd's immediate context. By the start of 1995, and unlike other CHE's, Canterbury Health Ltd had achieved a marginal rise in available hospital beds, precisely six, and were providing volunteer staff with free use of car parking facilities. This was the good news. However, at this time and more importantly, Canterbury Health Ltd was grappling with the financial problems that had seen them subjected to government monitoring in 1994. By this time, it had been placed in 'workout' (a process in which officials worked with them to draw up business plans to have them financially viable by the end of 1998). A year on, Canterbury Health Ltd was still working on ways of breaking even and had not achieved a tangible path toward the national Government's goal of getting them on to a sound financial footing.

The next year, 1996, was to be a highly significant one for Canterbury Health Ltd, one of the two major providers of health and hospital services for the South Island. Under closely connected circumstances, its chief executive had changed, it was facing an internal crisis of high proportions, and it had fallen under the spotlight of popular media coverage and the microscope of extreme external criticism. To end 1995 the organisation had made the news by cutting cleaning positions on the eve of Christmas. Public perception of the national health service was not good for the organisations that comprised it, remaining in the public view a collective institution "where treatment is

. . . [not] available for those who need it, . . . but those who can afford it" (Sunday News, 24 December 1995, 1, 11).

James (1994) provides another view of this change. The reforms were motivated by Treasury panic at rapidly, and seemingly unstoppable, rising health costs. So the reforms were credibly presented by their opponents as cuts and readily accepted as such by the public. The reforms emphasized commercial criteria in the management of service delivery, which enabled opponents credibly to label them 'American'. Overarching the politics were two powerful factors. First, information about hospitals' assets, equipment, operational costs, and methods was sketchy and unsystematised. Second, the sickness industry was, and is, infested with vested interests with a financial and professional stake in blocking change and with a powerful grip on the public psyche because of the mysteries of medicine and the need ordinary people have of the practice of medicine.

Another snapshot of this change is provided by a clinician from the time. This combines the two major variables in the arguments for and against change, money and people, and the tension that has to be held in suspension between these two elements while discussing effective health management.

> *Under the health reforms of the previous government, there was an expectation that things would be tightened up and that there would be a more business-like focus. There were allegations at that stage that there was waste in the system ... if in fact we could get more commercial and get more business-like then things would improve ... There was a tighter financial focus ... clinicians ... tended not to have much interest in that. There was a tighter focus on outcomes. What should we be delivering both in terms of organisational efficiency and also health status gains i.e. how should you spread your dollars around the range of possible health interventions and who has priority and how should you ration and that sort of thing in a context where demand always outstrips supply ... a variety of things became part of the change of the culture ... [It was] the way that it was handled ... in the early days of the reforms that polarised the clinicians and management. The clinicians felt disempowered and so on ... some of the focus on business issues lost some of the complexity of the health sector, of health decision making which can't be likened really to running a supermarket or turning out tyres and so on and so forth. I mean, if we were going to be truly commercial, a whole lot of patients we wouldn't see here - basically they are awfully costly and they're end of life and all those other sorts of things ...*
>
> *Clinician respondent, 2000*

The micropolitics of change: Canterbury Health Ltd's internal environment

As already noted, dramatic change has spread across the business world in the last two decades. This change has covered the realms of geopolitics, consumer and financial markets, technology, government policy and legislation, macro-economic stability and capital flows, corporate organisational forms and practices, and the politics of the environment (Greenwood & Lachman 1996). The impact of this macropolitical change has fallen heavily upon the body of New Zealand health professionals. Efforts to tighten up accountability were sometimes construed by doctors as an attack on professional autonomy. Efforts to alter duties and standards towards increased 'quality' were sometimes construed by nurses as an attack on professional ability.

Health services are almost inevitably politically salient. The way that they are run and operate reflects macro-environmental values, divisions and matters of debate. Canterbury Health Ltd had shown each of these facets of reflection by the time of the CEO's appointment.

Health also possesses an incredible network complexity. The clinical-managerial relationship will be described in the next section. There is the combination of statutory and non-statutory agencies referred to already also. Throw other interest groups, such as unions, the public, and the media, into the mix and it can easily be seen how this dynamic comes to exist. The emerging role of patients as 'clients' in the co-production of professional services adds another angle to this (Greenwood & Lachman 1996). Understanding this complexity as it relates to Canterbury Health Ltd's own predicament in the years 1996-2000 is central to understanding how and why outcomes of change have emerged as they have in that time.

The local context of health management

In understanding the context that Canterbury Health Ltd is a part of, the respective professions of managers and clinicians need to be appreciated and understood. A perception of managerial ability as a profession has grown out of the traditional background that classical strategy formulation is a part of. Managers form the central role in this view of strategy and change management. This approach has already been described. To understand managers, this approach to management must be fully appreciated. Similarly, with doctors a background rooted in tradition explains much of the way that this group operates to this day. The strength and pride that currently exists within this profession is attributable to a legacy of power and involvement in

the important public institutions of this country from New Zealand's earliest times. So it can be seen that there are powerful egocentric forces at work within the health sector, as in most sectors today.

It appears that a certain paradox exists between doctors and managers. Managers, by classical virtues of the nature of their job, are concerned with long-term, future outcomes of performance yet their turnover within organisations remains high and is a characteristic of the current age. Doctors, on the other hand, whilst dealing with patient matters wrested firmly in the short-term and daily battle for survival, demonstrate decidedly greater longevity within the organisations that they work for.

It is easy to be both applaud and fault the general job done by managers. Their work is never easy and they are certainly often caught between opposing ideas and factions, seemingly in a 'no-win' position. It is an invidious task and one that is done well most of the time. After all, in line with the tendency of what can be described as the national psyche, it seems that only when matters go wrong that the media, with any apparent speed or vociferousness, broadcasts issues of management. So it appears, on first appearance, with managers in the case at hand and this idea shall be explored later on in later, analytical sections of this paper.

Likewise, it is both easy to praise and criticise clinicians. The clinical staff surveyed in the course of this study were striking in their intelligence and articulateness. They possessed a certain arrogance with this as well. After all, they know that they possess expert power and that ultimately the hospital will only work with the their general approval and co-operation. As a result, they might be sometimes very stubborn or pig-headed. In 1994-1995, some doctors demonstrated this sort of defensiveness. As one of their group commented, "[When the restructuring started happening] a wall rose in the hospital ... with sides being taken ... Those who wanted to work with management were isolated by [others] ...".

To a degree, similiarities exist between managers and clinicians. Both are self-interested, status and power driven. Clashes between the two, when they occur, could be based more on this similarity than any perceived divergence. Neither group is particularly so idealist. However, certain differences exist between the two, especially in the area of power and power sharing.

Managers are in charge of people by sociological definition and make decisions. Doctors and nurses are highly skilled workers by definition. Management can delegate

this role of overseeing and governance that is management and this is what the CEO has tried to achieve. Doctors are professional and have traditionally existed in some form; managers are quasi-professional (i.e. possessing neither a unified or codified body of knowledge and training) having evolved out of the changes in organisational structure and growth in industry and globalisation of the last two centuries.

In summary, it is important to note that members of each group recognise that innate differences exist between the two groups and that the perspective of the other is valid despite being different. The following extracts taken from conversations with members of each group within Canterbury Health Ltd this year for this research bear this out:

> *But when it comes down to whose arse is toast when the budget blows, mine is pretty immune. There's not much they can do to me ... I am a doctor whereas it's [my service manager's] career so she gets much focus and pressure than I do. So essentially, though we are equal in responsibility, we aren't equal in terms of culpability.*
>
> *Clinician respondent, 2000*

> *Until we can actually make [our values] real for clinical people so that they can see 'oh, that's how it relates to me' we are not going to get any change or buy-in ... clinical people think in a different way than management people ... their focus is more treating a particular patient at a particular point in time - this day, this week whereas management often have to think longer-term in three to four years down the track as to where the organisation's going to be and so often we talk past each other all the time for those sorts of reasons. But that's okay, you just need to know that and manage around that so that you can make some things real for clinical people ... they are here for the long-term ...*
>
> *Management respondent, 2000*

The management of health services involves dealing with people who deal with the very lives of other people. The group referred to is that of clinicians, comprised of both doctors and nurses, each representing professional bodies of standing and respect in their own right. The fact that this wider group deals with the sanctity of human life means that dealing with them, for one reason or another and neither for better nor worse, can be a very intricate process. This intricacy again bears testament to the complexity of the human network involved in health services management.

Brent Layton once described managing clinicians as a process not unlike "herding cats". This comment figuratively encapsulates well some of the individualistic peculiarities and traits that belong to this group. Doctors especially exude confident

levels of self-belief, refined idiosyncrasy as reflected in a wide vocabulary and sharp sense of intelligence and wit, along with a great level of personal power regardless of whether or not this actually exists in practice. Levels of ego are concomitantly high as well and ego is by no means a pejorative element in itself.

This combination likely stems by virtue of the fact of their involvement at a deep level with patients through which their own role derives a greater sense of dramatisation. The power, to save or redeem life lies, quite literally, within their own hands. Their apparent self-righteousness is at least partially explained by analysis on this level. The difficulty involved in this management of doctors is reinforced in the admission of one that "if you ask doctors the same question, you will get as many answers as there are doctors ... To try and get a common view and a common direction is almost bloody impossible." Layton might have been right.

Another anonymous clinician expressed their opinion on doctor resistance to co-operation with management as this:

> *There's a lot of things that you need the public system for but you would never openly admit that because it's the platform on which your private practice runs and you get the status from taking the private cases that would never go through a public system. You get your research capacity. There are a whole lot of things that go on that say you need to be in the public system. Having been in the public system, you don't necessarily like the way that the system runs because you don't have the control of it.*

As a result of the combination of these interpersonal dynamics, there really is something about the place of any health and hospital service, this country over. It is all of a function of the size, the structure, and the interpersonal complexity of these services. This must really make a tightly unified culture quite a difficult thing to capture. What needs to happen next is that more members of each group try to bridge the gap or at least understand and attempt to communicate that understanding between other members of their respective group. This is an essential part of an approach that can be termed developmental. In terms of formal change management, this approach to understanding needs to be imparted and transmuted from above. At present, this approach (as symbolised by management behaviour of this type) does not seem to occur enough.

As a result of these complicated and dynamic internal factors it would appear that:

> *[Clinical staff need to be involved] and at a much greater level. You're dealing with highly qualified and in some cases very naive, arrogant professionals who don't ever*

want to admit that they don't know. So if you go in and antagonise them, you're going to get a fairly swift response even if it is the right thing you've done. You've got to handle it very differently, you've got to understand the politics, you've got to understand the processes you go through, you've got to use them properly ... there is something very unique about working in the health area, about administering change within it. If you think about it, we talk about managers as seagulls. They fly in and crap all over us and fly out because the people that really change are the people delivering the service. You don't see nurses changing a lot, you don't see doctors changing much - in terms of staff turnover. But you look at managers, a very high turnover exists. The people who actually deliver the service are very consistent. Standards don't change very much. Technology comes and gets upgraded sure, but the forces that change are the political environment, the managers that have to enact the political environment, and managerial philosophies ...

Management respondent, 2000

At this section's end, two questions readily pose themselves. Are these internal protests symptoms of a system focussed more on shorter-term economic ends (rather than longer-term developmental ones)? Does a health management system need to be this way implicitly under the commercial environment of the day (in other words, do these type of organisational results simply go with the territory of broader economic constraints or can they be ameliorated despite this context through choices made within the individual institution)? As shall be seen in a later section, the answer to the first question clearly appears to be 'yes' and the answer to the second question, a resounding 'no'.

Institutional backgrounds

The discussion that follows is treated in alphabetical order after the largest institution, that of Christchurch Hospital, is discussed first. The entire case study is the amalgamated product of a series of separate case studies based on the intra-organisational institutions that together comprise Canterbury Health Ltd.

Canterbury Health's main job is to care for people who need hospital treatment or care. By their own information, they provide a full range of urgent and non-urgent hospital services for Canterbury people (468,000 approximately), and in some cases, for the rest of the South Island and further afield. They have about 4,000 staff and that makes them the biggest employer in the South Island. They run eleven hospitals including the largest in the South Island, namely Christchurch Hospital.

They also operate the facility where most Canterbury babies are born, Christchurch Women's Hospital. Another of their major hospitals, Burwood, provides for most of the sum of spinal patients in New Zealand as well as providing operations and recuperative care. A fourth major hospital is Ashburton Hospital, which also manages a number of country hospitals. Additionally, Canterbury Health provides the most sophisticated laboratory services in the South Island.

What Canterbury Health Ltd doesn't do is provide hospital or community services for mental health. A different Hospital and Health Service (HHS) does this. This is Healthlink South, which operates independently of Canterbury Health in Christchurch. It is quite probable, however, that in the coming period these two institutions will, in fact, merge services. The combining of two HHS's would bring with it ostensible gains in economies of scale in some important areas, along with other potential economic benefits.

The corporate vision of Canterbury Health Ltd exists to provide high quality health care services for our patients and customers. It aims to serve people in Canterbury and beyond by providing high quality secondary and tertiary health care services, tertiary training and research activities that will gain us recognition as a centre of excellence (Canterbury Health Ltd 2000).

The CEO, current chief executive officer, explains. "The most valuable asset we have is our staff. Their skills, initiative, suggestions and enthusiasm for their work and

development of services are what make Canterbury Health special. Everyone's input, at every level, is highly valued. We encourage staff to make a significant contribution as the input and suggestions provided by each staff member allows for continuous improvement to the services provided for our patients. Senior doctors and nursing staff directly manage their areas of responsibility with business and management assistance. We believe that all staff can and should make a difference in the way we deliver health care to our patients and it can't be left to someone else. All staff in management positions are required to ensure good two way communication exists within their areas of responsibility."

"We will support and assist staff to continue their professional development when they join us. It's important that we all keep learning so our services can improve. This is part of our focus for quality improvement. There is no end point to improving our service – it's a job of ongoing continuous improvement at every level. We expect and welcome staff input into this. As health services in New Zealand continue to adjust to the needs of their communities so, too will Canterbury Health. As the largest Hospital and Health Service (HHS) in the South Island, we continue to focus on being a centre of excellence in service, teaching and research and a significant factor is the ongoing input from our staff to increase our effectiveness in health and in our improved efficiency."

Commenting upon the HHS's approach to change, the CEO had this to say. "There will never be a shortage of challenges facing our hospitals, services and staff because the process of improvement should never stop. There is no end point. Our aim is to continually monitor the care we provide with a focus on continual improvement" (Canterbury Health Ltd 1999).

In 1999 Canterbury Health publicly embarked on a journey of quality improvement which aims for accreditation by the New Zealand Council of Health Care Standards (NZCHS) by the end of the year 2000. What this means is that Christchurch, Burwood, Christchurch Women's and the Community Hospitals will need to meet internationally recognised standards of health care which are incorporated into the standards applied by the NZ Council of Health Care. This year staff have been analysing procedures and standards to see how they fit with the standards laid down by the NZCHS. This has meant visiting different departments, talking with staff about the standards of their operation and matching it with the requirements of accreditation.

"Many areas will find that they are already well on the way to having the systems and processes in place that are required within the accreditation framework", points out Shona MacMillan, the Quality Manager at Christchurch Hospital. "What we need to do now, is focus on those areas where gaps have been identified through our Quality Improvement programmes, and to work with staff and managers to achieve the best possible standards, and as a result continue to improve the quality of care for patients."

The case of Christchurch Hospital

Christchurch Hospital is the largest tertiary, teaching and research hospital in the South Island and provides a full range of emergency, acute, elective and outpatient services. Doctors and specialists here also travel to major centres in the South Island providing specialist clinics and operations for some conditions. A new consultation service, called Telemedicine, is also available whereby specialists use video camera links to hospitals in other parts of the country. Patients' conditions can be discussed; the patients seen on camera and x-rays shared via the video links to provide consultations, all without patients needing to leave their hometowns.

Christchurch Hospital has the busiest Emergency Department in Australasia, treating more than 65,000 patients a year. The Department has recently had a multi-million dollar redesign so it now has better work areas, more monitoring equipment and an Emergency Observation Area which allows patients to be monitored for up to 24 hours before being admitted to wards, if appropriate. The Department has also had a major increase in staff, particularly in the number of specialised emergency physicians and senior nurses working in this area.

Many of the doctors and specialists working in the hospital are involved in world-leading research. Often, they are engaged in joint projects with staff at the Christchurch School of Medicine, part of the University of Otago. The School is integrated on the hospital campus. Christchurch Hospital is the major tertiary teaching hospital in the South Island where doctors are trained and the facility is one of the four main teaching hospitals in New Zealand.

The busiest time of year is usually winter. Hospital beds are often full and resources stretched. To ease the pressure, some patients are transferred for recuperation, once they are no longer seriously ill, to another Canterbury Health hospital. In particular,

respiratory and cardiac patients are transferred to Burwood Hospital once they are on the mend.

As already noted, management-staff relations at Christchurch Hospital were in dire straits by the end of 1996. At that time, many staff were only too quick to inveigh much of what management attempted to do. Management, for their part, was defiant in response to this criticism, applying rigidly to what it considered to be management's rightfully ordained duties. In the argument over who should hold the lion's share of the power in decision making at the hospital, the then chairman of the Canterbury Health Ltd board, Brent Layton, made it quite clear that he felt that certain absolutes existed. He was reported as saying that, "the authority and accountability that [goes] with decision-making *must* (emphasis added) remain with management" (Press, 15/6/1996).

The years 1995-2000 have seen significant improvements both in and because some of the elements already mentioned. In 1997, a much petitioned for Heart Unit opened. This led to the realisation of the dreams and hopes for many members of the hospital staff and public, at large. It remains a crowning achievement of the era led by the CEO. There have been a series of collaborative initiatives between Canterbury Health Ltd and other HHS's. Of late, success has been forthcoming in the ongoing battle to contain the spread of viral infection in winter. This year has witnessed a recession in the number of epidemic-like strikes of prior years. This has been at least partially due to the record number of influenza vaccinations that Canterbury Health Ltd has administered under a concerted offensive programme against ill health within 2000.

The hospital now has a fully functioning Heart Unit, after a 23-year battle to obtain this facility. This service is run by a joint venture between Canterbury Health and Health Care Otago. It is funded to provide approximately 260 cardiac surgery procedures a year and 300 angioplasties. It seems that these numbers will grow - the service was only established in 1998.

In mid-January 1999 the new General Manager of Christchurch Hospital, Mr Garry Smith, arrived. An important focus for him appears to be the support of staff in the continued development of an environment that both allowed innovation and change and provided security.

The case of Ashburton Hospital

Ashburton Hospital treats and discharges about 4,000 patients per year and mainly services the rural community in which it is based. The hospital provides maternity services, intensive care, acute medical and surgical services, assessment, treatment and rehabilitation services, acute admissions, and long term care for elderly patients and surgical procedures. Outpatient services include physiotherapy, occupational therapy, radiology, laboratory and an extensive range of community health services. Recently the hospital, which has under-utilised theatre facilities, has been helping out Christchurch Hospital by performing operations on Christchurch patients. This has proved very successful with patients able to receive their operations much earlier than they would if they waited to have their procedures at Christchurch Hospital. The hospital has been accredited by Quality Health NZ (NZ Council on Healthcare Standards) since 1993. The management team is also responsible for those rural hospitals of Darfield, Ellesmere, Waikari and Akaroa. By 1999, Ashburton's bed numbers increased following shortened hospital stays and increased geriatric care by private providers.

Ashburton Hospital has been accredited for the last six years and has been able to give valuable assistance to the Christchurch team.

The case of Burwood Hospital

Burwood Hospital provides the most specialised service in New Zealand for treating spinal patients. The Burwood Spinal Injuries Unit is also involved in world-leading research to help spinal patients to rehabilitate and adjust. Respiratory and cardiac patients are transferred here from Christchurch Hospital for rehabilitation. At Burwood they learn to look after themselves before they return home. This has proved very successful with very few readmissions of patients. This, in turn, decreases stress on Christchurch Hospital by helping prevent readmissions to busy wards there, especially in winter when the highest patient numbers are treated.

It performs the greater part of elective orthopaedic surgery for all patients south of Hamilton. Burwood Hospital has also recently won and performed multi-million dollar surgical contracts for ACC and it is looking to perform surgical work for accident patients who are covered by commercial insurance companies. Other services provided at Burwood include a Primary Birthing Unit, Pain Management, Public

Health Nurses, Vision/Hearing Testers and Community Paediatric Therapy. The Hospital is also the site of the Champion Centre for children with learning disabilities, Parafed Canterbury and the Melrose Wheelchair Factory. The Burwood Spinal Unit has successfully completed ISO 9002 Certification.

The 1990's have marked ground breaking work in hand surgery and tendon transplants which greatly assist tetraplegic patients in regaining movement in their hands. More recently, Burwood has extended its surgical services because of the work it is performing for private insurers. Burwood has also made significant ground this year in reducing injury time loss, the time it takes to get people back to work after an injury.

In 1997 Canterbury Health clinicians and management decided to establish a special ward at Burwood Hospital specifically for the education and rehabilitation of patients with respiratory conditions who needed careful ongoing management. The following year the ward expanded to include cardiac patients needing rehabilitative care. Clinicians and health professionals agree that this combined cardio-respiratory ward has been of great additional benefit for patients and staff alike. It is a practical model of integrated community care. Involved with the central hospital and local general practitioners, the service not only teaches patients how to manage their illness once they leave the ward, but monitors them more closely through agencies like the Cardiac and Respiratory Outreach Service.

Indeed, in the late-1990's Burwood Hospital won a major contract with ACC for work to be done at it. This underpins Burwood's reputation as one of the premier rehabilitation and orthopaedic hospitals in New Zealand. This reputation is complemented with a national and international reputation for its spinal work. Patient surveys have shown that late arrangements are proving enormously successful.

The case of Christchurch Women's Hospital

Most Christchurch babies are born at Christchurch Women's Hospital. This hospital also provides gynaecological operations and services, pregnancy and parenting education, a mid-wifery service, social work, counselling and physiotherapy. The hospital has a neo-natal intensive care unit for premature babies and staff are involved in world-leading research involving improved care for pre-term babies. Women's

Health Division is also responsible for running the maternity hospitals at Rangiora and Lincoln near Christchurch, and the Lyndhurst day unit.

Perhaps the most significant development for this hospital over the last five years has been the decision in 1998 to shift it from its stand-alone position and relocate Christchurch Women's services to a separate purpose designed area mainly on the Lower Ground Floor of Christchurch Hospital by 2001. The Canterbury Health Board of Directors unanimously agreed upon this decision at the Board meeting on November 4th, 1998. Christchurch Women's Hospital had been part of the Healthlink South health and hospital service until 1993.

This decision followed lengthy public and internal staff consultation and the consideration of all opinions, suggestions and material relevant to the issue. It was based upon an awareness of the need to improve the comfort and quality of facilities for patients as quickly as possible as it was recognised that current facilities were essentially past their "use-by" date. A purpose-designed area, with its own separate entrance is being built so the link between womens' and childrens' health is strengthened. Medical staff have felt for some time that the women's and children's services would best be sited on the Christchurch Hospital campus where maternity and gynaecological services would be in close proximity on the Christchurch Hospital site where paediatrics is based. There has historically been strong staff links between the two sites. This was one reason why there were concerns when Canterbury's health services were split in 1993 between the two local HHS providers, Healthlink South and Canterbury Health.

The principles that governed the design of this change have recognised a commitment to ensure that women's and children's services are not incorporated into the existing Christchurch Hospital ward structure. The women and children's services would be distinct and separate. A separate entrance for the Women's and Children's Hospital would exist. Separate management, with their own General Manager and the retention of the existing Women's Health nursing and management structure and the inclusion of children's health, would prevail, along with a focus on preserving the unique identity, family and wellness focus of the service. Such commitments manifest a strong integrity in the management of this change. More family areas, toilets and showers of an appropriate style for patients, single rooms, and car parks will also be provided for in this shift.

Following extensive staff consultation, planning is well underway for changing many of the wards and service areas in Christchurch Hospital to make the facility better able to delivery top quality service to patients. At the same time, plans for integrating the Christchurch Women's Hospital services largely into the Lower Ground Floor of the riverside of the building are also progressing, in consultation with staff.

Summary

Canterbury Health Ltd has undergone a range of experiences over the years 1995-2000. This range of experience, in part, reflects the wide and disparate nature of the individual institutions within the Canterbury Health Ltd context and health in general. The dominant issues facing the organisation at present are listed below in summary form. Since the CEO's entrance into the organisation in late-1996, he has taken active steps to address each of these areas where they have remained problematic. These are further discussed in the following section focussing, as it does, upon analysis.

Matter related to structural transformation:

1. External collaboration with other health service teams
2. Financial return gain
3. Frame-breaking research and change
4. Political health reforms
5. Quality assurance drive
6. Waiting list lengths

Matters related to cultural transformation:

1. Aftermath from the Stent report
2. Debates over incentive remuneration
3. Internal, interpersonal difficulties
4. Medical misadventures

As a preamble to the discussion of the next section, a brief overview of each of these areas follows:

Matters related to structural transformation:

External collaboration with other health providers

Under the management of the CEO, a number of collaborative projects were introduced. For example, collaboration occurred with private health providers (for community support), other HHS's (Healthcare Otago for child cancer services, Southern Health for sub-contracted services) and the Christchurch School of Medicine (for research). This reciprocity signalled closer co-operation between major organisations within the health sector. In the words of the CEO, these collaborative efforts were all "about working smarter, doing the best for patients and saving some money along the way". The CEO and Southern Health chief executive Anthea Green worked together in Australia and this contributed to outcomes of alliances and mergers between Christchurch Crown Health Enterprises and those of its Southern neighbour. Both shared similar views on hospital services and looked at several areas where they could co-operate including eye services, joint medical appointments, joint management of laboratories along with contracting out Southern Health Ltd's payroll services to Canterbury Health Ltd. The combined effect of this co-operative approach to health tended towards the provision of better health care (economic resource usage and the development of patient services) in the South Island.

Financial improvements

The pattern of net profit for Christchurch's public hospital services steadily increased over the period 1996-2000. By 2000, Canterbury Health Ltd was among a minority of State health and hospital services to have made a profit in the last financial year. Naturally, the Government encourages state health service providers to achieve a financial surplus. They are legally allowed to keep and reinvest these profits into health services and infrastructure. In the budget-strapped organisation that Canterbury Health Ltd represented in the early part of this period, investment in Human Resource Management didn't take a high priority. This had quite significantly changed by its end. Investment in training and development per dollar head of staff member has almost doubled in this time and is now recognised as a much-needed allocation of financial backing.

Health reforms

With the election of the latest Labour government significant changes have been made to the structure of national health systems. Out have gone the central Health Funding Authority and local Hospital and Health Services, such as Canterbury Health. In have come new democratically elected District Health Boards, intended to be more responsive to community needs.

While the notion of elected health boards might sound like a return to the old Area Health Boards, the functions of the new entities are broader. They will take over at a local level the funding role now carried out nationally by the Health Funding Authority, with other funding responsibilities being carried out by the Ministry of Health. This means that the boards will be both funders and health providers, through their ownership of hospitals. The boards will inevitably face tension between their various roles. On the one hand they will be the funders for private sector professionals in their areas, such as general practitioners and other primary care organisations. On the other hand they will have ownership of hospitals vested in them, meaning they could be tempted to direct money to these structures. It was precisely for this reason that the funder-provider split had been originally introduced. Another potential difficulty will be the board membership. Given the need to ration health spending, board members face an invidious task. As political animals they will be lobbied furiously by health sector groups and by regional interests.

In the South Island, for example, one obvious parochial issue will be balancing the urban health needs with the desire of rural areas to retain existing services. Tensions will also exist with the Minister of Health. Despite the emphasis on democracy and openness, the minister will retain both responsibility for their actions and also significant powers over boards.

At present there is no figure on the scale of the one-off transition costs, or the extra spending that the new boards will entail. The boards of Canterbury Health and Healthlink South have already pre-empted any decision on their respective fate by deciding to merge. The biggest difficulty confronting the new system remains political. The DHB structure will have less than two years of operation before the 2002 general election. Any improvements in the over-all health of New Zealanders will take far longer to achieve and be measured.

Quality assurance drive

Over 1996-2000, Canterbury Health Ltd has pushed all of its institutions towards full operational accreditation under ISO 9001 institutional standards. As already referred to, most of these operational areas have reached appropriate levels of certification. Some important areas remain outstanding and the press for accreditation as it affects these areas continues.

Waiting lists

Waiting lists have dropped significantly since 1996. Despite this, pressure to further reduce these has been brought to bear by public expectations on health and hospital services across New Zealand. The achievement of these results in Canterbury Health Ltd has been greatly helped of late by the extra spending of the Fifth Labour government, combined with the excellent communication, negotiation and information presentation skills of The CEO. Canterbury Health Ltd has moved away from being the worst institution in terms of its waiting list management. Health Waikato Ltd now holds this unenviable position, followed by Canterbury Health Ltd. It remains unclear exactly how definitive the implementation of a new booking system for patients on waiting lists within Canterbury Health Ltd has been in achieving its results.

Matters related to cultural transformation:

The aftermath of the Stent report

Following on from reports of alleged system failures within Christchurch Hospital submitted by clinical staff in the 1995-1996 period, an independent inquiry by the Health and Disabilities Commissioner's office was conducted. By the year 2000, the corporate management of Canterbury Health Ltd stated that it that had enacted the report's recommendations and invited the Health and Disability Commissioner back to check on its services. Despite this, today some clinical members of the Christchurch health services team remain skeptical.

As a result of this inquiry, it was realised that the system of contracting, the principle mechanism by which quality was said to be assured under the health reforms of the 1990's, completely failed to provide patient safety. The report showed that severe

mistakes within the Christchurch Hospital health management system and that the reform process in Canterbury Health Ltd was done badly. The report was especially pertinent in its description of a chaotic situation in the under-staffed and under-resourced Emergency Department. Significant changes at Christchurch Hospital were implemented too quickly with inadequate communication between management and staff. Management tried to 'push through' changes without allowing staff time to work through the issues and 'buy into' the objectives. The resulting 'major culture shock' undermined morale and had an impact on patient safety. The report also stated that poor communication about proposed restructuring in 1995 had created an atmosphere of speculation and distrust, and an environment in which senior staff felt marginalised and totally disenfranchised.

Central to her criticism, and to the debate leading to her inquiry, was the decision not to include clinical staff in decision-making. "Canterbury Health failed to communicate to staff its vision, objectives, policies, and decisions", Mrs Stent said. "Nor did it effectively communicate its plans for organisational change. As a consequence it could not effectively involve staff and get support for strategies to deal with the financial difficulties in which the organisation found itself." Management also showed a lack of leadership. Mrs Stent said good leadership entailed developing and sharing with employees the vision and purpose of the organisation. It required inspiration, strength of conviction, open communication, clear direction, and decisive action. Notwithstanding this no one in either government or the institution accepted ultimate responsibility.

Incentive payments and performance management issues

The public disclosure of information regarding incentive payments taking place within Canterbury Health Ltd created major ripples across the organisation. The major issue in this circumstance revolved around the issue of bonuses to a select few of the health management staff, these payments being based on an exclusive set of performance related criteria. The recipients of these payments were largely management and not clinical staff.

Internal interpersonal difficulties

Whilst external indicators involving financial and research performance have improved, cultural factors within Canterbury Health Ltd have not ebbed positively to the same degree. Industrial relations have not been settled over the period either.

Nurses and junior doctors have both expressed their disappointment with internal conditions on various occasions within this period. While these groups have been and remain unhappy on points such as pay and parking, optimism somewhat paradoxically flows from corporate management upon the achievements of its governance with respect to its internal constituents.

By 2000, the CEO's view on this matter was that, while there were major staff concerns and media reports about the delivery of some patient care and the state of internal staff relationships when he arrived, "the issues that gave rise to these stories have been thoroughly examined and we have moved on". He states that this is an indication of the internal health of the hospital. "Staff consultation and input are the cornerstones of a healthy hospital. There are many examples of this occurring, particularly with the contribution of Clinical Directors and Senior Nursing and Allied Health staff. The Clinical Planning and Policy Committee, formed almost two years ago, has also helped to contribute staff's opinion and at Board level there has been enormous input from staff. The Clinical Planning and Policy Committee consists largely of elected staff representatives and now includes members of the Christchurch Hospitals' Medical Staff Association. We meet regularly to discuss important issues facing the hospital."

This optimistic view is not, however, shared by all staff members within Canterbury Health Ltd. Management might have paid lip service to the ongoing need for cultural development and increased love between organisational members. As Gary Smith, Manager of Christchurch Hospital (1998-2000), made quite clear on his arrival, there remains a huge need to keep working on fixing internal staff relations. This healing greatly seems to need to continue.

Medical misadventure

Various examples of this glare out over the period under discussion as far as this is concerned. Botched operations, blood transfusion and endoscope disasters exemplify this. Some positive aspects have been seen to come out of these incidents with new, higher and national standards being established.

Organisational results

Achievements and their management

1996-2000

Financial results

Under the management of The CEO, Canterbury Health Ltd has turned around in some very clear respects. Its performance has been abnormal (in an exceptional sense) compared with other similar organisations within the country and markedly better than appeared likely at the start of his tenure. It is certain that, by the time this paper is published, Canterbury Health Ltd will have been legally transformed by name into the organisation known as the transitional Canterbury District Health Board. At such time as local body elections take place in 2001 this new Health Board will be established with permanence, to a degree that political forces will determine in years to come.

The newly merged organisations of Canterbury Health Ltd and Healthlink South comprise this Board. These organisations are the largest providers of tertiary medical care in the Canterbury region. Together these organisations bring with them into a state of co-partnership, some sizeable successes over recent times. Canterbury Health Ltd has made significant gains and improvements in key hospital performance areas during 1996-2000 as detailed and below.

Gain/Improvement	**1996**	**1998**	**2000**
Financial operating performance	- 14,000,000	- 10,670,000	+ 2,350,000
Patients waiting for operations	NA	13,000	8,498
Patients waiting for specialists	NA	15,000	10,200
Patient satisfaction	NA	NA	90% (very good-good)

Source: The New Canterbury Health (Press, 2000)

From the time that the CEO came in he recognised the need for making a case and being an advocate for increased funding. Information use and lobbying by Canterbury Health Ltd began in order to address the funding discrepancies that it claimed existed. In 1998, Canterbury Health Ltd released figures showing that it was under-funded by $14 million a year. In 1998, Canterbury Health Ltd's chief executive said in his annual report that a wide range of statistical information was used during recent contract negotiations to convince the authority it should increase funding for surgical services in Canterbury. As a result, Canterbury Health Ltd received about $40 million more from its new contract with the Health Funding Authority. By the end of this year, Canterbury Health possessed only a $10.67 million deficit, a $4m improvement on the previous year's deficit and $7m better than was expected at the start of the year.

In 1999, Canterbury Health Ltd broke even - for the first time in six years. Until now, each year since its inception at the start of the health reforms in 1993, Canterbury Health had incurred a loss. Through presenting compelling cases to the Government for more funding, Canterbury Health Ltd demonstrated that it was under-funded in comparison to most other state health and hospital services. By 2000, Canterbury Health Ltd had continued to make gains. The Crown Company Monitoring Advisory Unit said that Canterbury Health had become one of thirteen health and hospital services to record operating surpluses for the last financial year through recording an operating surplus of $2.35 million.

So this petition for increased funding has worked for the short-term. It is however claimed by some that underfunding continues. While a brighter picture has emerged over recent times, much work remains to be done both in terms of reducing waiting times by some patients and eliminating debt burden.

Late in 1998, a prominent reporter for the main Christchurch newspaper paid tribute to the CEO:

> *Canterbury Health does appear to be better integrating some of its medical care. The move to Christchurch Hospital of maternity and other services from Christchurch Women's Hospital will put them nearer pediatric wards where they belong. The move is mostly because Christchurch Women's is outdated, and to refurbish it would cost too much but the relocation will nevertheless allow a better focus of mother and child health. Anecdotal evidence and a flood of figures should not, however, be allowed to obscure what still needs to be done. Canterbury Health Ltd continues to have problems. For example, although relations between senior doctors and management are much less tense than they were two years ago, there remains the residue of a clash of cultures. Inevitably, managers are driven by a need to achieve financial efficiency. That overlaps with, but is sometimes in contrast to, the medical profession's culture of care. Canterbury Health's chief executive ... has defused many of the difficulties he*

> *inherited from his predecessor ... That is not to say none are left. The senior doctors who stood firm against the rigid effects of the health reforms have been vindicated. They rightly insisted that patient safety had been compromised and should be paramount. Patient satisfaction is another matter. It might never reach the 90 per cent range. Sick people make many demands, some of them unreasonable. Even the most dedicated carers cannot address some complaints. They arise, too, when the health dollar is continually being pushed to produce greater value. Among some in the community, the notion persists that health budgets should be bottomless. Together with budgets for education and welfare, they account for more controversy than almost any other spending. There must be limits. Yet aggressively driving down budgets can have unfortunate human consequences. A hospital cannot be judged just by its heading towards the black. Other, less easily measured indicators of its performance, such as staff morale, are as valuable. The latest news, however, shows Christchurch Hospital making progress. [The CEO] can take much of the credit. He took over an institution that in many ways was fragmented and battle-scarred. Increasingly, it is becoming one of which Christchurch people can be proud.*
>
> *Press, 28 November 1998, p.10*

The CEO has made other notable marks, advances and impressions. He has achieved the obtaining of improvements in cardiothoracic surgery and emergency medicine. To some extent, the Stent Report suggested that he has handled this last item quite well.

Service results

The most notable of what can be described as service results has already been alluded to, that is, the cutting of waiting times for surgery, especially heart surgery. By 2000, Canterbury Health Ltd had halved the number of people waiting more than six months for heart surgery in the last year. Health Funding Authority senior project manager John Allan said the reduction was caused by extra surgery after more funding from the Health Funding Authority, as well as operations performed under funding allocated by the Government to cut waiting times for elective services around the country. Over 1998-2000, Canterbury Health Ltd reduced elective surgery waiting lists by about a third. The Chief Executive said increased funding and resources had helped cut the numbers (Press, 11 August 2000, 8). Patients waiting for surgery had dropped from 12,219 in October 1998 to 8235 at the end of May 2000. People waiting for specialist assessment were down from 14,400 to 9900.

A central indicator in the improvement in health services over 1996-2000 is seen in customer satisfaction results. These for 2000 showed that patients rated hospital care experienced in Canterbury Health Ltd very highly. More than 90 per cent of Canterbury Health patients surveyed have found their hospital experience good or

very good. The survey was part of a Ministry of Health quarterly review of Hospital and Health Service performance. More than 72 per cent of Canterbury Health in-patients rated their over-all satisfaction with the service as very good, with almost 20 per cent rating it good. A further 5.5 per cent said it was adequate, while 2 per cent rated it as poor and less than 1 per cent as very poor. A total of 602 in-patients were surveyed. For out-patients, the results were even better with more than 75 per cent of the 596 people surveyed rating the service as very good and almost 18 per cent as good (Press, 16 October, 4).

A summary of other intangible achievements achieved under the CEO's nominal leadership and direction:

- Better use and communication of information through the implementation of management information systems
- Decreased waiting lists and steady shortening of waiting times for non-urgent surgery
- Increased central government health authority funding
- Increased collaboration
- Better image in public perception
- Better labour relations

According to some prominent media sources, the fall in waiting times and time taken for consultations with specialists can, at least partially, be attributed to the implementation over time of an effective booking system (Press, July 4 2000). The decision to contract surgical operations to other local health providers is also likely to be partly attributable for this decrease. Health authority funding has risen and this seems largely due to the CEO's clever management and presentation of information. This will continue to remain within Canterbury Health Ltd's direct control for the short-term as its role as a part of the wider new District Health Board involves the oversight and allocation of health funding. The increase in positive public image appears due to a combination of clever communications and a time-synchronous drop in the image of general practitioner doctors due to the well-publicised fall from grace of some key individuals from this field. Lastly, better inter-collegial collaboration and labour relations where they exist are at least a part function of the CEO's overall style and delegation of management.

The range of attitudes towards these achievements varies between clinicians. From antagonism, through pragmatism, to status quo, clinicians side with management in

personal ways and for reasons that are contingent on personal circumstance. As one clinician notes, the political nature of the hospital as a workplace ultimately determines the allegiance of any given health professional to corporate management or otherwise. The following anonymous clinician quote belies the pragmatism of some and the place that individual perception plays in assessing the way that change has taken place within the Canterbury Health institution under the leadership and management of the CEO.

> *[If you were to ask everyone the question, you'd] get a mixed viewpoint from different groups and they'd be very polar probably. It would generally depend, probably, upon how they perceived their own situation because I think that, fortunately or unfortunately, most people ultimately react according to their own situation and their own immediate environs. Some choose to react according to the wider perspective and the greater long-term vision. In my own area, things have not changed for the better or the worse since [the CEO's] time. My perception is more from what is happening from a wider viewpoint. There would be other units that have done well. The units that do well, under [the CEO], would be those that have remained quieter. It sounds terrible but that is the way that things happen.*

Crises and their management

While Canterbury Health Ltd under the overarching management of the CEO has made considerable progress in wide areas, the years under his leadership have not been trouble free. The crises that have loomed and the problems that have been encountered in this period are now treated on a year-by-year basis within this sub-section.

The aim of this section is to better understand how change has been managed in the organisation over the period that the CEO has been involved in the management of Canterbury Health Ltd. These crises and their management are further analysed in the third section of this paper devoted, as it is, to a full discussion of management of change and crisis styles under the CEO's headship.

1995-1997

Matters related to structural transformation:

Poor financial performance

Canterbury Health Ltd was grappling with major financial problems at time. This saw it subjected to government monitoring in 1994, when it was placed into government supervised 'workout' along with Auckland Healthcare Ltd.

Fears of decreased funding

Ashburton Hospital, especially, feared that it was going to lose funding within Canterbury Health Ltd. These fears were to be allayed however, at least partially, by the news that boosted funding would be received through the Health Funding Authority, this being $14 m in the early-middle stage of 1996 with more to come later from reserve government funds (Waiting Times Funds).

Growing waiting lists

At the advent of the CEO's tenure in charge of the Canterbury Health Ltd helm, the patient waiting list situation appeared to be quite desperate. In late 1996, it was estimated that the organisation needed an extra $27 million to $30 million to clear the backlog of patients on its surgical waiting lists.

Matters related to cultural transformation:

Power struggles at Christchurch Hospital

By the start of 1996, a serious breakdown in communication had occurred within Christchurch Hospital. This developed into a confrontation and standoff between its staff and the Canterbury Health Ltd board. For months, management and staff had been embroiled in a dispute with senior clinicians over alleged patient safety problems and a lack of clinical involvement in decision-making. Doctors and nurses had sought a joint decision-making role with management involving "real partnership decision-making" (Press, 4 February) and had bemoaned the plan to restructure nursing services under earlier management. The doctors warned that patient care would be

compromised if the changes were made. Management had denied that patient safety was an issue and was reluctant to give the doctors the decision-making involvement they want. The issues were about power, adapting to political change, and the quality of health service provision at Christchurch Hospital. This was capped off with senior hospital doctors giving the strongest response against the health reforms in a national survey by the Association of Salaried Medical Specialists. These fractions were manifest through some vitriolic public comments by people with high profiles within the community. Nurses went on record as saying, "our career structure is gone. We feel unheard and unvalued ... We'll end up with unskilled people looking after acute patients" (Press, 4 February 1996) and "loyalty (is) earned and (comes) from constructive dialogue with staff, not from threatening scriptures of a departing chief executive officer (CEO)" (Press, 22 June 1996). A union official summed up the thoughts others with, "the hospital system is top heavy with management, who couldn't run a party in a brewery. Our people are having to put up with incompetence on a daily basis, which amounts to slow torture" (Press, 8 June 1996).

Politicians even got in on the act. Lianne Dalziel had this to say: "The [Christchurch Hospital] system has become a bureaucratic nightmare more concerned with financial risk management than giving people operations" (Press, 8 June 1996). Helen Clark added: "We have an extremely arrogant board chair and management at Christchurch Hospital and I think it is completely unacceptable for our senior specialists to be told they risk dismissal if they speak out. There is a climate of intimidation there and just a complete unwillingness to listen to what the people who take the blame when things go wrong have to say (Press, 2 October 1996)". All this opposition was not placated by then board director, Brent Layton's insistence that "the authority and accountability that [goes] with decision-making *must* remain with management" [emphasis added] (Press, 15 July 1996).

A certain irony was also noted regarding Canterbury Health Ltd's motto of "Manaaki tatou: Caring for everyone". At this time, it did not appear to be representing a comprehensive public health service where treatment was freely available for those who need it and not just those who could afford it. Claims of inequity had been raised. This view had been magnified with both board and management decisions to make volunteers park in the street and to shrink bed numbers.

Public criticism focussed centrally upon the management and standards of the management of Christchurch Hospital in particular. This criticism found its ultimate support, however, in a campaign, backed and financially supported by many of the

clinicians at Christchurch hospital, for an inquiry into the way that safety in the hospital was being compromised. This criticism included claims of understaffing, stretched resources, inappropriate staffing, failing to heed repeated warnings from staff on safety issues, and a failure to meet standards already established. This marked the beginning of the campaign that was to lead eventually to the publication of the Stent Report.

Support for cardiac surgery

In 1996, Christchurch Hospital was badly lacking a cardiac-surgery unit. This was clearly recognised by both the incoming chief executive and dedicated campaigners alike. The CEO went so far as to say that this absence made Christchurch "international laughing stock". He claimed that there would be "hell to pay" in Australia if a facility such as Christchurch Hospital, in the biggest city in the South Island, had to send patients such a long distance for heart surgery (Press, 4 September 1996). His drive appeared to be the catalyst needed to finally drive this investment initiative home. It certainly a popular groundswell for it. To this end, he had the joint support of all of the other South Island crown health enterprises.

1998

Matters related to structural transformation:

Closure of country hospitals

Towards the later part of this year, doubts began to arise over the future of two country hospitals, with both those at Darfield and Ellesmere likely to face closure after June 1999. At this time, however, reassurances were given by, the then prime minister, Jenny Shipley about the remaining open of Ashburton Hospital's 24 hour acute service. The CEO lay the blame for these doubtful futures squarely with the Health Funding Authority.

Debate over health services for women and children

In this year, the Canterbury Health directors decided to close Christchurch Women's Hospital in favour of developing a new service for women and children on the Christchurch Hospital site. The move was expected to cost between $20 million and

$30 million. The cost was significant, but the CEO said Canterbury Health wanted to boldly develop a service that would serve the people of Canterbury through the next 20 years. He said, "We are looking for the solution that will work best for everyone". It was claimed that the public and staff consultation process was ongoing, and had helped management identify how some services should be configured. Not all clinical staff agreed however. This is an example of incongruity between staff and clinical perceptions. This sort of divergence has led to disagreements and, as an issue, dogged Canterbury Health Ltd over the last decade. It is analysed later in the section that relates the conceptual framework of this paper to the management of change, of which this is an example, within the organisation. Like the clinicians, the board believed there were important clinical advantages in having all mother, baby, and child services on the Christchurch Hospital site instead of over two sites as at present.

New surgical booking system

A new surgery booking system was supposed to replace the old waiting lists from July 1998. By the time that that deadline was reached, this had not fully taken place. The new approach required patients to be assessed and awarded points mostly for the severity of their condition. Criteria include levels of pain, suffering, and disability, as well as life expectancy. As a result, over thirty thousand patients remained were left facing a longer wait to receive learning their fate under the new surgery booking system by the year's end, especially for varicose vein treatment (Press, 1 December 1998).

Junior doctors pay

While a strike was averted, nearly two hundred and fifty junior doctors employed by Canterbury Health threatened industrial action.

Matters related to cultural transformation:

Implementing the Stent Report

The Health and Disability Commissioner early in 1998 released the Stent Report (the outcome of the investigation into safety matters at Christchurch Hospital that was the product of the staff campaign for attention to this area of 1996). Later within it, the CEO had appeared to invoke sizeable managerial action in order to rectify

institutional safety performance problems. Primarily, he had achieved this through system change.

This system change included:

- Adopting and continuously monitoring trauma indicators and regularly publishing reports on them to allow comparison with other Australasian centres.
- Ensuring senior medical staff review the requirements of their relevant royal colleges to provide quality assurance systems competence. This was to be overseen by the New Zealand Medical Council.
- Reinstituting a professional development programme for nursing staff. A professional development co-ordinator for nursing was appointed and a programme established.
- Developing a policy to address conflicts of duties, including conflicts in relation to public/private practice and research.
- Setting up and monitoring credentialling committees. Credentialling is a professional obligation of specialists, and should be led by clinical groups. A corporate clinical advisor was appointed.
- Establishing a clear internal complaints mechanism to address staff concerns regarding quality of service.

Of the Stent Report's seventy-six recommendations on patient safety at Christchurch Hospital, only six were still to be implemented by mid-1998. This implementation was part of "ongoing quality and service development", according to the CEO (Press, 4 October 1998). These changes, however, had neither prevented nor dissuaded relatives of two dead patients seeking amends and restitution through legal action. Some staff also remained disgruntled and dissatisfied.

Management-clinician relations

While the differences between the CEO and his clinical staff had to some degree been moderated by 1998, some relationships were still very strained. Some of his biggest opponents were considered 'hard-liners' by other staff and management alike. In the CEO's words, the relationship remained "not as bad as some people think ... we have our differences but we're certainly not estranged" (Press, 14 August 1998). Management and clinicians continued to share some common goals, one being to make Christchurch Hospital the best in New Zealand. Some senior surgeons had added their voices to calls for more medical involvement in managing Canterbury

Health by April 1998 and they continued to petition for extra rights and responsibilities in terms of management and decision-making on operational issues.

1999

Matters related to structural transformation:

Patient assessment

Building upon what has previously been commented about the new booking system for waiting lists, in 1999 public outrage and dissatisfaction brewed strongly as cases of people lowly prioritised under this system gained publicity. For example, a Christchurch man with a gangrenous leg was told there was no guarantee he could get an operation in six months (Press, 19 March 1999). The inhumanity and inflexibility of this system continued to raise the ire of the public as the year wore on as patients waiting for treatment gathered in Christchurch and compared scores under the new booking system with some having horror stories to tell. One man required hernia and heart surgery but needed the heart operation first. For angioplasty he was given 61 points and booked for surgery. When surgeons opened him up, however, they found his arteries were worse than expected and that he really needed a heart bypass. For this procedure, he was awarded only 54 points, and was taken out of surgery and put on to the wait list. Some critics claimed that inequities such as these should not have proven unexpected and certainly were nothing new as they were an historical legacy based on underfunding.

Endoscope disaster

A major crisis occurred at Christchurch Hospital in July 1999 when its management was forced to recall thirteen hundred patients after faults with equipment had meant that a health infection scare had emerged. They may have contracted serious infections after inadequately cleaned equipment was used on them in the process of conducting gastroscopic or colonoscopic investigations in the gastroenterological suite. Senior clinical staff, furious that they were not informed of the problem immediately, called for an independent inquiry. Patients were horrified. Some staff were told just prior to the release of this information to the media while others heard only through unofficial sources. This contrasted sharply to Canterbury Health Ltd

management's knowledge of the cross-infection potential since the end of April. Christchurch Hospital Medical Salaried Association deputy chairman Evan Begg said the few staff who knew of the problem were sworn to secrecy by management. A Ministry of Health inquiry found that Infection control policies for cleaning endoscopes at Christchurch Hospital were not properly followed. It was not the result of sloppiness so much as a chapter of errors involving false assumptions, lapses in procedure, poor staff support and limited staffing levels.

Heart surgery

Despite increases in funding for heart surgery at Christchurch Hospital, 1999 saw the public perception remain that there were still too many people waiting too long for heart operations.

Junior doctor shortage

The flight of doctors, many of them juniors, to work in more lucrative jobs in Australia was well reported in the media. It was claimed that the number of doctors leaving was leading to an acute shortage of medical staff (Press, 16 December 1999).

Matters related to cultural transformation:

Clinician disgruntlement

Earlier in the year, some hospital medical staff had warned of more patient deaths as the lead-in to winter began. Some of the doctors that blew the whistle on patient deaths at Christchurch Hospital believe patients felt that patients could again be at risk this winter. The CEO said he was extremely concerned the clinicians were blemishing the organisation's outstanding clinical reputation. He said none had brought their concerns to the appropriate committee (Press, 28 April 1999). Among their claims were that operating theatres failed to meet safe standards, some surgeons were not getting appropriate support, that their clinical planning and policy committee was being sidelined by management, and that new systems of governance were desperately needed in the public hospital sector. They also remonstrated about the failures of the new booking system and the hasty decision-making on the move of Christchurch Women's Hospital to the Christchurch Hospital site.

On this, the CEO stated that the scoring of patients and their priority was entirely a clinical matter and surgeons make these decisions. He failed to see that the failure of this system was a system fault and that the system had been implemented by management decision. The operators of the system, namely the clinicians, were not to be blamed. He also said that the said back-up staff was the responsibility of clinical directors but made no mention of how or where they could procure the necessary funding for this from. Thus, overall, the CEO rejected the doctors' claims, saying they should have discussed the issues with him face to face, not in the media.

The doctors did however admit that many of the deficiencies highlighted in the Stent Report had been addressed. Wards had better access to ECG machines, staff were redeployed to high workload areas, technicians had relieved medical staff of time-consuming administrative work, funding had improved, the emergency department was considerably better resourced, and the hospital now had a heart unit. However, they said, the ideology that led to the systems failures had not changed and they repeated the point that clinicians are not properly represented in Canterbury Health's planning processes and that staff critical of management decisions were largely excluded. To this the CEO responded by pointing out that hundreds of hospital staff served on thirty-five committees involved in important aspects of running the hospital. He said that staff were routinely consulted and had enormous input into decision-making at every level and that there had been more than forty formal staff consultations on the women's hospital issue, extensive public consultation, and senior doctors had made representation to the board.

Nurses unhappy

The New Zealand Nurses' Organisation prepared to take strike action over obtaining "a fair deal and equity". Women's health and public health services had been contracted to Canterbury Health Ltd since 1997, but staff were on different contracts to other Canterbury Health Ltd personnel. Management wanted them on the same contracts as other staff, which would cause most employees to lose between $500 and $4000 a year. Some nurses were given a 3.75 per cent increase over almost two years and the strike was averted.

Claims of information spin-doctoring

The public relations section of Canterbury Health Ltd came under media scrutiny and fire later in the year 1999 (Press, 3 September 1999). It appeared that 'news' was

being carefully managed in order to hide the truth and that barriers were being placed between reporters and the people who work in hospitals. As a result, freedom of speech and the flow of information in and out of the sector were among the biggest casualties.

2000

Matters related to structural transformation:

Accreditation

During this year, it was publicly stated that Christchurch hospitals were lagging behind in gaining accreditation from Quality Health New Zealand (Press, 21 July 2000). About a third of New Zealand's public hospitals had already received accreditation from Quality Health. Christchurch Hospital, Burwood Hospital, and Christchurch Women's Hospital had not yet received accreditation, although Ashburton Hospital had been accredited since 1997. It appeared that Christchurch institutions were lagging behind in gaining accreditation and that there hasn't been a lot of encouragement within the system for achieving it. The head of Quality Health stated that their priorities seemed to be based far more on financial bottom lines rather than quality for the patients. Christchurch Women's had been audited by Quality Health a month ago and Burwood Hospital was applying for accreditation later this year. Christchurch Hospital was planning on applying in 2001.

Changes to health structures

In September 2000, it was announced that Christchurch's two health and hospital services were to formally merge and that the name Canterbury Health Ltd would be retained with Healthlink South retaining its name as an operating division of Canterbury Health. An outcry nonetheless arose over the manner in which Healthlink South's chief executive, Jane Parfitt, was informed of her dismissal.

Ongoing complaints and litigation

People continued to vent disapproval on local and national health reforms and happenings within New Zealand over the last decade. This was highlighted by a letter written in August that read, "Sir, I was amazed at your editorial (August 7) urging

Health Minister Annette King to stick with the current health structures. The National Party's health reforms, with their lack of accountability and monitoring, their fragmentation, their secrecy and their emphasis on the balance sheet at the expense of patient safety, have given us patient deaths at Canterbury Health; the Gisborne disasters; loss of experienced staff at Capital Coast Health because of a ridiculous experiment with the market model; a shortage of nurses, doctors and specialists because no planning structure for the future has been put in place; huge gaps in the healthcare experienced by Maoris, Pacific Islands people and lower socio-economic groups; a ranking below developing countries in world health statistics, and so on. The list is seemingly endless. The editorial admitted that [the present system was not perfect]. What an understatement! I welcome the return to a democratic and transparent model and a strong public health service as a result." Adding to this, families continued to seek answers to questions relating to the incidents in 1996 which led to the Stent Report investigation. No real accountability for the deaths that occurred then had been forthcoming. As a result, court action had begun.

Waiting lists

Lastly, throughout the year Canterbury Health Ltd struggled on in its measures to reduce waiting lists. Figures revealed in a Health Funding Authority report, show that Canterbury Health is still struggling to shake long surgical waiting lists caused by years of under-funding. Some progress had been made since the introduction of the new booking system a year ago.

Matters related to cultural transformation:

Hospital management styles

Public opposition to the use of bonus payment systems and the prevailing commercial ethos within Christchurch Hospital's single general manager hospital structure continued into this year. This was despite the CEO's attempts to placate public opposition through assumedly logical 'market' arguments. The heat generated by his reaction to the debate on this matter appeared enormous. One taxpayer wrote, the CEO "is quite correct when he states that people who oppose bonuses are a real problem to him. Of course bonuses should be paid. The trouble is that, under his regime, the bonuses go to the wrong people" (Press, January 10, 2000). Another wrote, "If ... [the CEO] ... is such an adamant supporter of bonus payments, perhaps

he might consider financially rewarding all his staff, who daily face the brunt of cost-saving measures, instead of just the few" (Press, 14 January 2000). Reactions, as typical as these were, showed the depth of resentment that the commercial model for hospitals that persists and also that the culture of care that is integral to the work of many health professionals remains at odds with much corporate practice. Canterbury Health Ltd paid $1.195 million in bonuses to about 100 senior managers and clinicians last year.

Divisions in radiological service

The Radiology department at Christchurch, once one of the best in the country, slid into a grim shambles after being split by private contracting of services, it was reported during 2000. In 1999, six of the hospital's radiologists resigned - half of the department's specialists. The group, members of the Christchurch Radiology Group, left to work full-time in private practice to cover short staffing and their split with Canterbury Health Ltd was amicable. Canterbury Health Ltd, however, has struggled to maintain a quality radiology service since the split. There had been poor staff relationships among radiologists for more than 10 years. A review by a local medical professor, Buchanan, finished in October 2000 informed that some radiologists barely spoke to their colleagues and avoided being in the same room. He also described bullying, harassment, innuendo, and malicious rumour within the department and as being wider within the hospital. The CEO said the conflict was not between staff and management. It was conflict between two groups of radiologists who work part-time for the hospital while also being partners in rival radiology practices.

Outflow of nurses and junior doctors

At the start of the year, filling junior doctor posts and satisfying nursing union requests carried on being ongoing issues for Canterbury Health Ltd management. Doctors continued to be lured over to Australia and nursing staff continued to feel mistreated and manipulated. Strike action was again threatened and partially delivered. One nurse expressed her thoughts as this:

> *As a third-year nursing student I feel frustrated and undervalued when offered minimal pay rates such as those proposed by Canterbury Health, after the immense commitment and money I have put into gaining a nursing degree. I am concerned that patient safety and quality of care may be compromised due to staff shortages should I stay and work in New Zealand. There are no incentives for new graduates to stay in this country, such as those being discussed with junior doctors. Consequently, I am one of many nurse graduates seeking work overseas where better pay and*

> *working conditions are offered. I would like to see incentives established that value the nursing profession and encourage us to remain and work in New Zealand.*

Conditions of work and remuneration remained significantly higher for those prepared to travel internationally. As a result, nursing and doctor shortages, at some levels, continued to spiral out.

Staff morale

At various points in this year, low staff morale was reported. The common thread was that clinical staff felt that doctors and nurses continued to work harder but the recognition kept going to the managers.

A typology of annual challenges for Canterbury Health Ltd 1995-2000

From an historical scrutiny and assessment of these years, it has become apparent that there are clear trends in Canterbury Health Ltd's development over the period 1996-2000.

1995-1997: riding change
1996: a year of new strategic management
1997: a year of awareness building

1998-2000: a steady recovery
1998: a year of transition
1999: a year of significant results
2000: a year of approaching maturity

In summary, then, by 1999-2000, Canterbury Health Ltd has begun to dramatically turn around the drastic financial deficits of the mid-1990's. How this turnaround has been achieved has already been touched on, linked as it is with the head management

of the organisation under the CEO. This is further explored in the next section of this paper under the analytical scrutiny that it provides.

Gaining a fair price for services bought has been part of the success package. This is directly attributable to the CEO's skills as a compiler and communicator-presenter of information. As a CHE, Canterbury Health Ltd had faced problems because of the nature of its South Island constituency. South Island hospitals tended to be smaller and offered fewer specialist services, so Canterbury Health dealt with a large number of referrals. Its main purchaser, the Southern RHA, thought its prices were out of line with those of other CHEs so it had to convince them on a case-by-case basis that they were realistic.

The successes of the last few years, characterised as they are by this financial lift, have certainly provided good news for an embattled organisation, rich in a history of inter-organisational conflict. Despite advances in financial performance, however, deep cultural obstacles remain to be overcome. Internal impediments to co-operation and cultural clashes still require to be better overcome. Issues related to be this will be further explored in the last section of this thesis as it relates to management within the health sector. What has been achieved also bears out some important points with respect to the relevance of positions under current organisational theory. This shall be examined in the first part of the implications section.

PART III MAKING SENSE OF THE CHANGE MANAGEMENT PROCESS

CASE ANALYSIS

Based on the framework set out earlier in this thesis, the action of change management perceived by the author to have occurred within Canterbury Health Ltd over the years covered within this study is analysed, by the triangulation of data sources, within this section.

The corporate management of Canterbury Health Ltd

It is accepted that the style of leadership in a health and hospital service is determined to a considerable extent by the type of structure of the national health system of which it is a part and, in particular, by its degree of centralisation or decentralisation. The CEO exemplifies this fact. Hard-nosed, autocratic, driven, focussing on results of an economic outcome – traits of the wider socio-political system in New Zealand at present. What especially, though, has characterised the management of the corporate body of Canterbury Health Ltd over the period 1996-2000?

In commenting on the style of his own management, and the wider corporate management of which he was a part, one factor became clear. Despite the rhetoric, and there was much of this, the degree to which meaningful consultation on change has taken place within Canterbury Health Ltd under the leadership of his era is lacking in terms of solid evidence. Corporate administration, however, appears to sincerely perceive that this has been both bountiful and effective. This is demonstrated in the next section.

Whatever the case, the ongoing future corporate-led management of Canterbury Health Ltd needs to devise ways to better develop consultation and meaningful collaboration between all of the parties present within the health system, especially the management-clinician interface. This is needed for the long-term survival of the organisation itself under the current system. Simply remaining the same in terms of style only produces inertia. More importantly, adopting such an approach will produce long-term growth and development (i.e. making the organisation better).

Certainly, the CEO had the time to do this - to collaborate internally - in some areas. He undoubtedly did not in other, more general and imminent, areas of decision-making. To this end, and supported by Dunphy & Stace's (1993) model, criticism of his management style is borne out. Much of leadership these days, as faced the CEO initially, is related to crisis management. The CEO faced crisis when he took up his position with Canterbury Health Ltd. The directive style that he employed was appropriate then and is appropriate to some degree within the fast-paced nature of his work. As time passed and the organisation evolved from this initial point, this style of management became less and less relevant and could have been discarded.

The process of change management necessarily requires 'softer' skills for which human resources management is renowned. Staff especially, as with people generally, basically want and need to be listened to an understood. It is not clear that the CEO has managed this process well personally. When people are not treated well, dysfunctional behaviour can result and subversive political processes out. Whether or not this is the result of corporate management style in particular, dysfunctional behaviour has resulted within sectors of Canterbury Health Ltd over the period under study. What is clear is that this behaviour needs to be attempted and continued to be arrested for the overall benefit of the organisation within the future.

At present, the Canterbury Health Ltd board seems to be doing a good job, adopting an appropriate role as far as governance goes. It does not seem to be interfering in operational affairs as it noticeably did under Layton's guidance. For the moment, the board makes policy decisions in conjunction with the chief executive. In the case of the CEO's time at the helm, he then put these policy decisions in place, bringing them to life through enactment. The only criticism that is pertinent to make comment on here is that, again, the reality of clinician participation in management decision-making does not seem to be as strong in practice as it appears in words. Many committees exist that outwardly possess some clinician input. This does not automatically translate into the full and fair involvement of this group however. Clinicians need to be both listened to and heeded as well. This involves acting more on their learned recommendation.

It was Euripides that said, "Men are men. They must err." He seems right. The pragmatics of the process of consultation-collaboration will sometimes mean that all parties are not fully satisfied however desirable win-win outcomes are and no matter how hard they are sought. This is the nature of life. Partiality, not perfection, dominates for the greater part of the time. Looking at Canterbury Health's corporate

management under the CEO from this angle, one then has got to admit that he has performed a positive total role.

To the case of the smaller organisations within Canterbury Health Ltd, then, for the CEO in his four-year tenure has done much to produce positive and organisational system-wide change in its institutions.

Institutional analyses

This section of work provides an overview of the primary achievements, accomplishments and initiatives experienced by the individual institutions that make up Canterbury Health Ltd over the years 1995-2000, along with an assessment of challenges that they might face in time to come. It is quite possible that key general lessons can be derived from situational analyses of management. Drawing these lessons is a contentious issue and suggestions made from these smaller case studies are presented later. Where possible they have been kept constructive and aimed at being aligned with the conceptual flavour of the document as a totality.

The case of Christchurch Hospital

It should not come as a great surprise that out of all of Canterbury Health Ltd's institutions that Christchurch Hospital, its largest, is behind the pace as far as the thorough enactment of organisational change goes. This is not to say that progress has not been made. Indeed, it has and in an abundance of areas. It does not appear that new policy and procedure (the product of change) has been codified and institutionalised as fully as possible. For example, infection control seems less well progressed than at other Canterbury Health institutions. Support for this opinion lies in the number of infection scares that it has faced over the period under study compared with these institutions. This could at least partly be explained as a function of its size compared with these smaller institutional bodies.

It is not just its size that operates as a restraint in the obstruction of change. Historical division and infrastructure makes change more difficult. Again, though, and due to these factors, reform in Christchurch Hospital is rightly the pinnacle of any change achievement and, given its progress to date, there should be no doubt that, as long as progress continues to occur, Canterbury Health Ltd's slow transformation will at last

be reflected in its figurehead division's climb to the summit of change. This traverse will be ultimately realised in Christchurch Hospital being fully accredited.

The case of Ashburton Hospital

Change has been mostly incremental here. Ashburton, due to its size and solidity in terms of lack of lack of conflict and lack of staff turnover, represents a very stable and productive environment for the management of health. Along with itself, Burwood and Christchurch Women's Hospitals are not under the same strains and forces that Christchurch Hospital is due to their relative lack of size. Accreditation pressures are the same. It is just that they are more easily brought to bear and placed under control. As a result, Ashburton Hospital appears very well organised. It has a well-codified body of policy that is actually implemented and reinforced by procedure. It possesses a loyal staff, with low turnover.

Of course, the accreditation process does not demarcate an end to change. As the CEO points out, change is an inexorable process, never finished, never perfectly realised. This is the challenge for Ashburton. To become a better and more constructive (not just productive) part in the total system that Canterbury Health Ltd is. The comfortable nature of existence there might well promote inertia and develop to be a major obstacle to future change. This needs to be constantly addressed through challenges. This idea is picked up upon later in the implications section under the notion of the promotion of creativity in order to ensure cultural growth and benefit, as well as organisational longevity.

The case of Burwood Hospital

Burwood Hospital has also experienced positive results under the accreditation process. The Spinal Injuries has already gained ISO 9002 approval. In October, further sections of the operation are due to go under the microscope of accreditation scrutiny. A continuing area that requires change is in the upgrading of its aged buildings and facilities. These capital needs will be balanced by the Board of Canterbury Health Ltd against other priority needs for expenditure.

The $3m contract with ACC for elective surgery has been a major boost for the hospital. It has represented a sizeable change and one that has been installed with high approval from both management and clinical staff. The connection of surgery and

rehabilitation is a hallmark of Burwood Hospital and its renown is largely based on the highly successful operation of each. Rehabilitation requires a commonsense approach. It is less high technology than many other areas of Canterbury Health Ltd, especially the operation of the Christchurch Hospital. This allows policy to be more people-driven, although it is still constrained by time-cost efficiency considerations. Nonetheless, the allowance for a certain pragmatism suggests Burwood to be a more relaxed institution than other similar, major hospitals.

The case of Christchurch Women's Hospital

The standards of compliance at Christchurch Women's Hospital seem pretty high too. Accreditation does not pose itself as too daunting a prospect for it. Change has been handled systematically and absorbed regularly over the years under Jim Magee's ostensible leadership.

The prospect of integration with Christchurch Hospital is most likely to act as the biggest challenge to Christchurch Women's methods of operation over the next two years.

Applying the conceptual framework

It is very clear from a detailed examination of the data collected through interviews that some quite marked differences in perception as to how change has taken place within Canterbury Health Ltd over the last four to five years under the overarching leadership of the CEO. These perspectives are best delineated in terms of optimistic managerial regard, clinical pragmatism, and clinical pessimism-opposition (antagonism or hostility). All three feature clearly in the analysis.

With respect to the conceptual framework of this paper, one perspective clearly dominates both feedback from clinical and management sources alike. Namely, this is that of an *economic approach* to change. Despite and notwithstanding the excellent bottom-line achievements that have occurred within Canterbury Health Ltd over the process of the last four years, this approach to change has problems attached to it in the management of cultural factors involved in the management of change. Bottom-line and quantitative achievements are indeed both emphases of this approach to

change management. The negative effects of this approach on cultural factors are explored in the sections that follow now.

A dominant approach to the management of change

It will be seen to be implied in the following sections that much of the management behaviour in Canterbury Health Ltd under the CEO's time with the organisation has based around purely economic considerations and that change has been based on such an approach. From interview responses of clinicians it certainly seems that it is focussed simply upon the economic side of the ledger. However, after reflection and the involvement of management input, it appears to be more balanced than this.

While it is probably not so consciously applied in practice, the interview data collected for this study resonates heavily with management commentary that appears to place objects and numbers over people. The implication here is that this group considers these items as superordinate to the latter group in terms of achieving management's own work. Economic, as opposed to developmental, ends appear to be considered more valuable by most of the respondents that were drawn from management ranks.

This, as will be seen, is the assessment of the author after more than just a cursory first look. A question however exists: has this approach been constrained and forced by pragmatic considerations of time and cost or has it, rather more, been chosen or opted for at the expense of a conglomerative (both economic-developmental) approach to change management?

There are many examples of this economic and associated elemental focus. The importance of information systems to collect operational cost and quality data appears to be a symptom of an economic focus. They connote a proclivity toward a focus that is away from people. The stations of Quality Manager, Accreditation Co-ordinator, Customer Service Manager and so on connote a focus on external satisfaction of economic demands in terms of public relations, statutory risk and institutional compliance (i.e. the politics of 'quality') rather than a focus on internal employee development and delivery (external service rather than internal service). There is HRM's focus on mandatory training areas of treaty and risk compliance (both economic) while other developmental areas, such as organisational development and

unit facilitation of change management appears to be seen more in terms of being optional.

Some of this cannot be avoided. Information management is an important part of the management role. People management is too. A good example of a facet of Canterbury Health Ltd's functioning, which balances these interests, is the use of PAUSE system at Christchurch Hospital. As an information system, it possesses an outward focus on values not just economic. It is a reflection of what Smith and Spittal (senior managers) and the HRM team is trying to achieve there. Under their guidance, developmental HRM values of honesty, integrity, teamwork, co-operation along with achievement are filtering through in practice, onto and beyond paper. This is having some impact on business plans and these values are starting to transmute through the hospital affecting inter-collegial relations and public relations for the better.

Examples of this approach

This approach to management through change by Canterbury Health Ltd under the strategic and operational headship of the CEO was manifest in a number of conditions. These are outlined in the next pages under the general headings of communication, consultation, capital development, risk management, restructuring, information management, and the CEO's own style.

a) Communication (external and internal)

This much was said on the matter of public and staff relations by members of Canterbury Health Ltd within interviews related to this study:

Anonymous clinician views:

> *Canterbury Health Ltd management in the mid-1990's ... employed ... a publicity officer, at a substantial salary, and [established] a local Canterbury Healthline which was a journal which purported to represent what was happening here but in fact was a propaganda journal. We know that because we tried to submit an article to that when our guys got an award from Noam Chomsky, a university academic freedom award and [a key member of management] refused to publish an article about the fact because it wasn't in the interests, he perceived, of the journal. So what he's admitting is the fact the he's using selective propaganda. He actually uses the term 'perception is reality' and he believes that provided that people out there perceive things to be going well then everything's fine. He doesn't really care that things aren't going well. It's a perception. So he will try and put on a brave persona*

out ... to the news media, and he's very good at handling the news media, which may not represent reality.

[Canterbury Health Ltd management] ... believes that you generate loyalty in the staff by paying large sums of money and that you generate the belief in the community that you're doing a good job by the use of the media ... this place has got a good news machine ...

[Senior management is] very good at [management by façade]. Terrific at it ... There is a lot of things that have advanced but in a way the problem is that they are advancing after the event. A bit like Cave Creek. An incident happens and so you make a whole lot of new plans and policies so that [it] can't happen again. So you structure things very dominantly so that things can't happen again. When in fact if you have the best attitude ... you'd pre-empt these things by having wide discussion, predicting problems that might be going to occur to make systems work prior to the event rather than after the event, being seen to do lots of things which you can tick the box from a public point of view but you miss the primary point. The main point in this hospital we believe is to get everyone on board so that we are all working for the same cause. You don't divide and rule so that we are competing with each other all the time, which is what's actually happening.

[Senior management] continues because the board above him supports everything he does, and the Crown Company Monitoring Advisory Unit has done the same too. They have told him what to do and he has done it. He would have been booted out a long time ago if this was not the case.

Anonymous management views:

Interviewer: It seems that you have handled the media well.
Respondent: (pause) Thank you ... I think it's most important to be available and open to them. To be able to tell them the good things and the bad things. You've got to be there and I think that's part of the obligation involved in running public systems. You've just got to be open. [People] don't want to hear from a spokesperson.

We were different in the way that we started to use [public relations staff] because [we] really saw them not as PR but ... as a communications piece and there is a difference. PR is the spin-doctor issue. Communication is really about communication with staff, communication with key people, with politicians and the public generally.

So then the CEO appears to have been a very good interface and networker with external groups and a convincing and cogent arguer. This aligns itself to an economic approach to managing change amongst daily operations, achieving results, as such an approach requires (see Table 1), by acting in a way that focuses on external ends, numbers and groups. The degree to which spin doctoring has occurred remains, in fact, both matters of debate and degree.

b) Consultation

This much was said on the matter of the type and degree of genuineness of consultation that Canterbury Health Ltd management under the CEO has undertaken:

Anonymous clinician views:

> *After the Stent Report ... managers still didn't want us to be involved in helping them advise how this hospital should work. They still wanted to only consult their small coterie and that situation remains to this day ... Isolated pockets make decisions rather than genuinely consultative and collaborative efforts ...*

> *There's certainly been a lot of systems put in place to make consultation sounds as though it happens ... Clinicians were put on to the committee to look at the site development. That would be one example of where they made quite a play of asking for input from clinicians but really they had made their minds up before they had really even started. They would come to [one medical group]. They would say 'there are really two options here ... and it's completely open here. There's been no decision made, okay? But we've actually talked to quite a lot of groups around the hospital and the physicians think it's a good idea, and the [other] people think it's a good idea - and after all, they are the ones that have to work there - etc, okay?' And then you go to [this other group] people and say 'did you people say it was a good idea?' and they'd say 'no, who said we did?'. And we'd say 'Oh, management' and they said 'Oh, they told us you thought it was a good idea'. So, there was a story ... and they use those techniques all the time, telling you that they've already had consultation with people who've agreed and it's not true at all. And then, if you challenge them on that point, as I have, they'll say 'Oh, it was our understanding that they did and we're sure they did really'. So there was a process that went on, of course, which was completely sham, there was nothing genuine about it at all and they'd decided before they'd ever even started that they were going to put it in the place that it was decided on.*

> *To some extent [consultation] is representative but to some extent it is chosen people ... I don't rest easily [with the current consultation process] as the people who have been elected there really because they have shown that they are for the managerial stance more than for the other side ...*

> *We believe that there is a little bit of a possibility [that] the stance has changed just a little bit. We hope that [the new health boards will] have a new influence on the CEO's choices, [which] will also have a new appointment on other managerial appointments ... [we] will thereby be in a better position to utilise the expertise that they have at the ground floor level to help the organisation get on with the job that it does best. Our belief is clearly that if we're alongside working together with management, us largely deciding the clinical things, clinical governance etc, management making it work, things can work ...*

The key thing about the current management as I perceive it, is that they have their objectives and they are going to go, advised to some extent by their chosen medical advisors, and pursue those lines independent of what other people around the place think ... My belief though and it's shared by quite a few others around here too is that the experts in the hospital in terms of clinical aspects have to be those who are involved in those aspects and they should be the people that advise management and management should seek their advice. Now, they don't necessarily need to agree with it all ... democratically management and all the relevant physicians must come up with a better opinion than a unilateral management opinion, okay?

Now, in a democratic system I will put my hand up and vote. If people disagree with me then I am happy with that provided that everybody has had their say and I've been voted down because of democracy. I'm happy with that. What I'm unhappy with is the fact that we are actually sidelined and not asked to be part of the process and that's the difference.

Now, I believe that the way it should work is that all people who represent nurses, doctors, other paramedical services, should be able to have their say through their representatives. Now, they should be able to have their vote along with management in all those things aiding management to make the decisions that everybody feels is best for the local organisation of health, taking into account all the same constraints, money, time etc, that we have to live within. But that way to me is far better ... than managers ... going about working towards achieving ... goals ... despite the advice that they are getting from other people.

A classic example is the shifting of Christchurch Women's Hospital to this place. Now that has huge repercussions in terms of every other department in the place. Management has their plan for that and it is almost an unbending plan. They make the pretence at consultation but they don't listen to the consultation but they say later on that they did the consultation because they allegedly did. They've ticked the 'consultation' box but even the people who were on their committees say this is run for management, it's not run from a committee point of view. They are not genuinely interested in eliciting feedback. They're doing exactly as they want to do. It's top-down all the way through rather than bottom-up. We believe in bottom-up. They believe in top-down. We see that top-down can never work in the long run because you're not going to get the people's help. To me it's like a management team excluding the consultant's, aeronautical engineers, involved in a shuttle project going up to space. Currently, management ... say 'you guys are too close to this so we don't want provider-capture, so we don't want your viewpoint. We want out viewpoint so we're going to design all these things' ... To me the better approach is to get all the experts involved in the first place and to get all these experts to make a democratic decision as to the best way forward and then when things go wrong, everybody's been consulted ...

It's a perpetuated system the whole way through which is basically the wrong system. It's the top-down model that is the wrong model. The model should involve all the expertise that you have got, utilise it to the best of your ability, get everybody to have ownership of the problem. Because if everybody has ownership of the problem what enormous strength you have when things go wrong. We can say then. "Gee, we did cock up, didn't we? But we did it the best possible way. We got the

involvement of the Ethics Committee, we got every expert in the hospital, we had a democratic opinion of the whole lot, we came to a conclusion together. Unfortunately, we did cock up, we did get that one wrong and we apologise for that. We've learned from it and we move on. That's a hell of a lot better than isolated little pockets making decisions, getting it wrong, and even when they do get it wrong they blame the others anyway because the way they've set up the system they can actually externalise the blame.

Anonymous management views:

Respondent: I think that [in the mid-1990's] management got stuffed up about who was running what. I think the board, the chairman and the CEO of this organisation started to run [operations] and I don't think that that's the way in which it's done. You've got general managers who do that. In May 1997, I put a proposition to all of the clinical directors – twenty eight of them - who were then answering to the GM ... saying why don't we try to organise six major groupings of clinical directors. You elect who you think you're appointees should be. We'll interview them and we'll appoint them to positions and they'll run each of your groups and you'll answer to them. You'll have then six people reporting to the GM but you'll be making the decisions you need to be making about boundary issues and a whole range of things about clinical practice. They didn't want to do that. They refused to do that.

Interviewer: Why not? It seemed democratic.

R.: The reasons I think ... One, they didn't trust one another. Quite frankly. Or management. And secondly, and this is the real crux of the issue of where we are today, is that for clinicians to put their hand up and become chiefs of services it means they have to wear some of the decision making and some of the responsibility and accountability. And the people that report to them have to accept the prerogative in making those decisions. Now that is a huge leap. And you don't go there unless you are willing to make the leap. We have just appointed chiefs of services over the last four months, and [when Gary Smith resigned] I ... put a committee of management together which is made up of chiefs of services.

I: The perception of some doctors differs on this point.

R: And I could tell you who they were. I could tell you who they were ... To give you some example, there are some really odd ideologues here who are politically motivated who won't make any bloody change whatsoever and will not acknowledge any change in the decision making process. And don't want to. Their process of decision making is that you give them all the power, all the budgets, all the money, and they'll make the decision. But don't ask me to ration health or patients because it's unethical. Now they're not my words. They are their words. Now I think that in a rationed system what we've got to have is an understanding of the partnership whereby clinicians share some of the responsibility. I don't want to wear the whole lot.

The CEO:

> *It's difficult to get everyone in an organisation of this scope to feel that they are heard as part of the decision making process. On a day-to-day basis it doesn't worry me ... In a futuristic sense, slightly more. If we are to make progress here, then specialty fields need to feel as though they are a little more in control of their own destiny.*
>
> *There was still the feeling for some time that clinicians weren't adequately involved in decision making at the higher levels and so certain committees and structures have been set in place that now give greater clinical input on a range of issues. I think that's working better. The polarisation seems to have decreased quite significantly. I think there's still an element of it there and folk I think are seeing a much better, more trustworthy and better handling of basic day-to-day, operational issues than was the case earlier on.*
>
> *There is an increasing involvement of key clinicians in the decision making levels ... more input by senior clinicians in meaningful dialogue with the CEO on key issues in the medical slot should occur ... such as Christchurch Hospital, under Gary Smith, has actually put in a new management tier which involves an operations manager, as a representative of management, a director of nursing, three to four senior clinicians, such as Kelvin Lynn, Chief of Medicine. This would have both a clinical governance responsibility and a quality responsibility as well as a corporate or budgetary responsibility for medicine ... so we'll get key senior clinicians acting as proxies for clinical directors who act as proxies for specialists all feeding into a key management group for Christchurch Hospital which will in fact have a dominance of clinical input as support for the General Manager ... this will be a good clinical model for the organisation as a whole ... This is Gary Smith's model, a Chiefs of Services model. When Gary was appointed, there were a number of balls in the air as to how we might go and the Chiefs model had been touted mostly by the physicians because there were so many clinical directors of medicine and they were all doing their own thing and some of them were quite small, perhaps two or three. There's one one-man group! So the Chief of Medicine becomes the line for all those people so you don't have the General Manager having 22 people aligned to him. Instead, he is given another tier (i.e. the Chief of Medicine) to pull together, co-ordinate, orchestrate the needs of this disparate group, because they all provide general medical services ... but having appointed senior, nominally respected, clinicians in those roles, genuinely trusted by the next tier down, interfacing with and influencing the General Manager in the running of Christchurch Hospital, you'd actually end up with quite a good model ... the commitment is to have this model in place soon ...*

So then the CEO appears to have either been a very good designer of cosmetic change or he has sincerely tried to act in a pluralist fashion, facilitating processes of fairer decision making. If the CEO moved fast to make cosmetic, positional changes then it is not clear. What remains is the continued need for clinicians and management to meet halfway. At the end of the day, it appears that some clinicians will work with management and some choose not to.

To his credit, the CEO at least has externally appointed a director of nursing to be responsible for all nursing issues, and a quality assurance co-ordinator, whose focus is on monitoring patient safety. In consultation, of some form, with senior doctors the hospital has also increased staff resources at its busiest times. The health and hospital service has at least appeared to work with senior doctors discussing changes they believed were necessary, and together examining what improvements could be made. It has also reviewed its structure to give doctors input into management decisions. It has also held elections for a new committee of doctors, nurses, other health professionals, and managers who would work together, sharing decision-making in clinical planning and policy matters to recommend what was best for patients and the hospital. While some of these changes have taken too long to be put in place, nonetheless they seem genuine.

Therefore, the area of consultation might align itself to an economic approach to managing change amongst daily operations, achieving results, as such an approach requires, by acting in a way that focuses on external appearance. Then, again, this might not be the case. A balance, most likely, exists.

c) The development of the Christchurch Hospital site

Respondents said this much upon this particular issue:

Anonymous clinician views:

> *That was a purely economic decision. It could be done quicker and cheaper ... They should have been moved on site many years ago. That isn't the issue. The issue is that they wanted a quick solution. It's another tick in another box that we'll have to live with ... and it's the wrong decision ... it won't be developable at all. It will barely meet their current needs. There will no room for possible expansion ... and ... it would have been so easy to do ... [with] the pressure you could have generated in Canterbury for such a facility ... you could have got enormous support ... the difference [between adding the new facilities on as opposed to building a stand-alone unit] was like $27m and actually, in terms of long-term health spending it is a drop in the bucket ... if in 5 years time we find that we have to build a stand-alone hospital it will be $500m ... it's short term, tick in box, yeah ... it was based around getting a quick, cheap fix ...*

> *The move was inevitable. In that sense, there was no consultation. It was always going to happen. But a consultation process had to take place, not only with clinicians but also with the community. There had to be a feeling of involvement by it*

> *... Not everyone feels that they've had a chance to be heard but you can't hear everyone ... There were committees set up, budget groups, which involved selected clinicians ... and I know some of them feel pretty disgruntled having gone through the process of discussing issues and then finding that they may not have gone in that direction ... through it all you do need someone who's prepared to make a decision and so in that sense you have [a senior management team that] is prepared to make the hard decisions and that's good, taking into account feedback. But sometimes those decisions keep changing and then people are not too sure where they're going ...*

So then the CEO appears to have been a fair moderator of opinion on this issue. This aligns itself to a balanced approach to managing change amongst daily operations, achieving results, by acting in a way that focuses on weighing up quite different opinions towards change and its ramifications. This integrates both economic and developmental approaches to change management.

The way that the issue has been moved through hints of an economic approach. Only time will tell to this point. If safety and health standards are not clearly attended to in the process of this shift and in the construction of these new buildings other people-related failures occur, then, again, an economic approach will be manifest.

d) The endoscope disaster and issue of risk management

This much was said upon the issue by those interviewed:

Anonymous clinician views:

> *What happened ... when a machine broke down that was supposed to disinfect the endoscopes that trained medical staff look down the throat and the bum with? ... All the data and things here indicate that this was known about for some considerable time and the information was kept from a whole load of us. It was kept under privilege amongst a very small group of people who took about 3 months to decide what to do about this major problem. And it's pretty clear that initially they thought they could sit on this because it would damage the organisation if it came out. Now, I'm one of the endoscopists who work in this unit ... None of us were told a thing about it. I was told about this just before it was released to the media three months later and so I'd been treating patients with dirty instruments and they hadn't told me.*

> *You can take the attitude that they argue now that they weren't sure what the risk was and so whilst they were determining what the risk was they wanted to keep the information secret. But if you take that course of action, by all ethical standards of practice, somebody has to be an advocate for that patient group to protect their rights and that should have been either the Health and Disability Commissioner or the chairman of the local ethics committee or both. But, no, no, they didn't do either of these things.*

[As regards positive change] ... It's almost been those [other things] at the expense of everything else and what happens is that those can almost get what they want because they are the public manifestation of progress. And they can get what they want while others can't. A classic example of this is what happened with the gastro-enterological problem, which you'd have heard about in the news where they had the endoscopes, which weren't sterilised properly. Now, prior to that, the endoscopy department had been asking for three new endoscopes for a long time - getting turned down all the time - when they had the huge gastroenterological problem they asked for three gastroscopes. [Senior management] said 'No. Have six.' You see, when a problem - Cave Creek - before the thing breaks I want five nails to solidify this thing. 'No, you're not going to get them.' When it's broken I want new platforms in every DOC place in NZ. 'No worries, mate. Have the lot.' You see what I mean. That's is what happens.

[This incident] illustrates very nicely what I was trying to say before about the way that I would handle that as opposed to the way that management would handle it. The way that management would handle that, although they won't admit it, was they wanted to have a risk management problem, the risk being what the public perception of this was. Manage the risk don't manage the problem ... I don't know what they thought ... They have to answer why. To us [it was] absurd. When you get a problem, our belief is that you say "Okay, hey, we've got a problem. How can we manage this the best for everybody concerned, particularly the patients?" The first thing you do is you get all involved into the room, all the experts into the room and say "How as a group can we handle that?" You don't say "Christ, who can we keep from knowing this so that the shit doesn't hit the fan?". You don't do that. You get everybody involved. You do the best thing.

So then Canterbury Health Ltd management under the CEO functioned very poorly in this instance. The actions of this management that surround this situation align themselves very strongly to an economic approach to managing change amongst daily operations, achieving results, as such an approach requires (see Table 1), by acting in a way that focuses on bottom line considerations of cost and risk. In this regard, health management has been viewed no differently to that of a financial corporation and this meant that management was run along corporate lines, with risk being managed by solicitors who minimised the legal risk to the organisation. This certainly backfired in this situation. The clinical staff involved were greatly let down and this will take much time to restore.

Another facet of an economic approach to management that this event might represent is that of shortsightedness, being reactive and doing only what is needed to save overt face, without accounting for intangibles. It is a lesson that needs to remembered and acted upon in the future. Once again, the affair gives great insight into some differences that might exist between that which can be referred to as a typical

managerial mindset and a typical clinical one. It highlights the organisational damage that can be done by the very worst of the attributes of an economic approach to management.

e) Information systems: a help or hindrance?

This much was said on this issue of how management information systems have been implemented in Canterbury Health Ltd over the time in which management has been under the CEO:

Anonymous clinician views:

> *Bringing Canterbury Health Ltd back on to financial track [would have been senior management's biggest achievement]. And by that I mean getting systems set up, information, management information, so that people can make decisions appropriately. Putting some of the controls back in. Getting the information to put the case to get correct funding. That's been dreadfully underfunded and everyone kept saying 'well, we're all underfunded' but [senior management] set up the systems to prove it, to show that it was the case. So he's really brought it around from being a non-performing, hugely deficit-based health system to being a performing, break even. So I think that would be the biggest achievement.*

> *It's [what systems senior management has set up] no good to us though. It doesn't help us at all. There have been several computerised information systems in my time. All costing a lot of money but none of them have provided us with the basic clinical data that we need. I mean, I ought to be able to go to a machine here and say how many operations did I do, what did they cost, how long was the in-patient stay, is their a trend, all that stuff should be available at the flick of a button. All sorts of people collect [the information] but I mean, if you look at it most of its garbage.*

Anonymous management views:

> *Yeah, that's a production and workplace status system that monitors on a weekly basis things like, on an employee basis, level of sick leave, level of usage of casuals, and from an operational perspective, number of admissions, length of stay, % of day surgery admissions ... we look at and analyse this information on a weekly basis. We should have it on a daily basis soon. It helps us look at the workflow within Christchurch Hospital. At the staffing level we get information particularly on nursing ... the focus is not only on costs but also the human quality emphasis that is sometimes attendant with cost e.g. ensuring patients only stay a day is both good for the person and restricts cost. A quality aspect is also recorded. This is mirrored in a low waiting time rate. We want to improve the service that we offer. Yeah, this is not just rhetoric. We are not the sole provider of health care any longer ... it's not just rhetoric although I can understand why one may be cynical about that. We have to report on quality in relation to how happy our patients are with respect to the*

services that we provide. We get a lot of complaints about the length of time that people have to wait in different places. So it is important that we know that sort of information so that we can make improvements. I think you'll find that staff are very focussed on improving things for patients and not just on costs and that's going to get even more so with the change in government who talk about something called 'clinical governance' which means that we have to focus on quality issues as well as cost. The two are not mutually exclusive. If we can improve a process and it means that we are able to be more cost effective and the patient has a better experience because of that then that's a double-whammy really! That's good. And remember we are using public money here so we have to try and encourage or breed a new way of thinking ...

We have to try and ensure that we are as responsible for the expenditure that we have as possible and it means that we can also then, and I don't think that it's down to this level yet, plough any savings back into staff development. At the moment the direct impact doesn't necessarily filter back down into the budget or be reflected at the cost-centre level. In an ideal world, that should happen.

So then the CEO appears to have been a very good at implementing these systems. The values that appear to underlie this change seem dominantly economic. They were certainly the initial drivers but may have been somewhat reconfigured to suit the purposes of human resources management, for example. This aligns itself to an economic approach to managing change amongst daily operations.

f) The CEO's style

This much was said upon the CEO's personal management style:

Anonymous clinician views:

He brought a fairly, um, ah, I was going to say a hard-nosed but I think it probably was a reasonably hard-nosed approach. He's somebody who's got good analytic skills, who's articulate, who's also a pretty focussed man. If he decides that this is the best way to go, he'll push for that rather than take a more laissez-faire approach to management. So, that meant that the polarisation that was there from the previous regime still remained for a bit because the trust had been lost and to build that up he either had to get more runs on the board or become more friendly and more sort of conciliatory, that's the word, and culturally sensitive and all that sort of political thing.

We ... have a very go-getting, hard-nosed CEO and there are some things that you can admire about him but he has a personal agenda which basically says 'I am going to achieve things this year and I am going to put so many ticks in so many boxes and woe betide anyone that gets in my way' ...

Positive change has occurred. But it's interesting how that's occurred. Early on it was recognised for example that the cardiothoracic unit problem, that we didn't have one! Dunedin did. So there'd be huge work for years to get that through. Finally it did come through and that was good. The only problem with that though is what [the CEO] is tending to do is choose cause célèbres and he chose cardiothoracic service and he chose emergency medicine which was in dire straits and he's chosen the shifting of Women's Hospital which are useful causes but it's almost been those at the expense of everything else and what happens is that those can almost get what they want because they are the public manifestation of progress. And they can get what they want while others can't.

Corporate headquarters overrides many decisions here made by the Hospital's general management ... it's always been the case. It's not a statement against [senior management]. It's always been the case ... but I think the CEO probably more so than some because he is intuitive, he's been brought up with health, he's got his vision and he wants things to go his own way, and he doesn't let go easily ... this is maybe more than is needed at this time because if you can't make your own decisions ... all the talk is bottom-up. Bottom-up budgeting. Bottom-up business planning. Bottom-up quality. The only bottoms up are those being put up and shafted ...

Some management views:

He tends to be quite a tough negotiator. He's very forthright, up-front, very direct and at times quite blunt but nevertheless he had, and this is different from the past, a vision of where he thought health should go, where Canterbury Health should be heading and certainly I think made a lot of effort to be more inclusive with health professionals.

During his time the CEO was no saint. He certainly rubbed some people up the wrong way. There are his detractors out there. Not everyone's in agreement that he's done a brilliant job but without a doubt, certainly efficiencies have been made. I think that Christchurch hospital is probably in a much better heart and running slightly better now and I think that the feeling in the place is that it is a better place to work in than what it was 5 years ago.

A new management came in in the form of [the CEO], and he brought in a style of management which I think was good and necessary for Christchurch Hospital especially ... he was very astute, very intuitive about the type of systems that we needed ... he took a little bit of adjustment but he put in the processes and placed changes that did work.

What's the CEO done? I think the CEO was seen to be a good advocate. I think that there were several things that he has done that have earned him respect, sometimes grudging respect but respect nevertheless. I think he's been seen to have been successful in his negotiations with Wellington which have been quite important. Successful also in working through some difficult regional issues in relation to the role of Christchurch in the broader environment. The South Island services that we provide, the relations with Dunedin and with some northern centres. So I think that he's been seen as a strong advocate for Christchurch and the health services here. In

sorting out basic things such as differential costing, pricing arrangements in different places across the country.

I think he's really just turned us around from an organisational process point of view. Quality assurance.

[The CEO's] made this place hum - budgets etc. Things happen. He takes the battles to Wellington. It's a new style that he's brought which I think has taken Wellington a bit by surprise because in the past some of these guys would tow the party line ... one has to admire it. In terms of the nuances however he is probably still a little too controlling.

I think he's got good vision. I think he sees clearly. The only thing that lets him down, at the risk of getting myself sacked, is this one fault: he's very unforgiving ... I wouldn't want to be a manager under him.

He's still ultimately more hierarchical and I think there's still an element of the tension between the collegial, medical environment and himself. I don't think it's just self-protection. I think a whole lot of the old-boy network, the collegial environment is partly grown really out of the medical profession's need, like any profession, to have a code of practice, to have support mechanisms for people working in a high stress industry and things like that. Those sort of informal support structures over against the more explicit managerialism that's come into the hospitals sector over the last few years, I think there's still some tension there but at least some of those issues are now being talked through in a way that I don't think happened with the previous regime.

I think part of the reason that he was brought in and part of the reason that he has been successful is he's an on-the-feet thinker. He's very capable, very quick, very intelligent, so I don't think that he would have come in with any really preconceived plan and I don't think that he's ever really had the opportunity to sit down and do one of those.

He's superb as a communicator, absolutely superb. He will hold forums on anything. He holds quarterly forums where he sets the direction where we are going, he lets people know how we are going. He might say this is what we are planning to do this quarter let's see how well we did last quarter and he'll pull up all of last quarter's goals and results. He keeps that communication going with both management and medical. He gets very involved in issues. He'll be fronting most of those issues himself but he has also set up policy advisory groups that have a very wide clinician base.

He's very street-smart with the media as well. You better have your facts right because he remembers things. Very directive and controlling of his relationship with them.

Anyone you talk to would say he's just brilliant in the public arena. Very good on his feet. Very good at getting the message across. Quite deliberate. Quite clear. He's got a very clear vision of where he wants it to be. He'll stand up to anyone. He's very determined, dogmatic. You see it his way or you don't see it. Very few people would stand and say you're wrong. He's a very determined person. Failure is not in

his vocabulary. The CEO would probably walk over his grandmother's grave to get where he was going. He's that strong and determined.

We have a CEO who is quite determined, quite sure about what he wants to achieve, isn't prepared to take any prisoners and you deliver ... It means that the way that one delivers to him has to be timely and it has to be exactly what he wants. The way that one chooses to achieve this is one's decision ... My view is that at our level then there needs to be a clear understanding of what is expected and people need to be left alone to do the job their way and achieve it. Others may not like the way that people choose to achieve things but the only time that others should intervene is if the job's expected results are not achieved. If you take this line, then if you say you are going to deliver then you have to deliver.

He's mellowed a lot. He's had to. As you move out of absolute crisis then people become a little less tolerant of intervention. So when you're in crisis you need someone to tell others do it this way and do it now. As you move out of that if you keep telling others what to do then people are going to start to say no and walk away. He has now got a team around him that he trusts and if the teams says butt out then he will butt out much more readily than he would have done say 18 months ago.

The CEO himself:

I attempt to make sure that there is accountability and responsibility by everyone in the decision making. That is fundamental. You want to have the joys of making decisions, you actually have to be accountable. That's the first issue. My style? My style's changed enormously from where I was in the first place to where we are now. Some people say it hasn't. And they would want that to be the case. But in reality it has because the organisation's changed and it's galling to have people say that your style hasn't changed. I mean, of course your bloody style's changed. That's like saying, you know, you've changed ... The organisation's changed and as the leader of that organisation you have engendered, encouraged and accommodated that change and that's what my job is.

Well I think that for a number of reasons we have tried to make sure that clinicians are actually decisions about clinical issues that they should be and for management issues that they should be and that I've tried to make sure that managers make the decisions about what they need to be making, fully informed. So I think try and make sure that both groups are more fully informed in the decision making that they are both required to do. I don't believe that we've inappropriately encouraged clinicians to be managers and managers to be clinicians. I think that we've tried to establish that there is a difference between the two and that we should applaud and welcome that difference but make sure that they're actually linked in a partnership arrangement.

There is very poor clinical leadership as an issue in the whole of New Zealand. There is only one or two organisations that I think we could say was doing the sort of clinical leadership that we would expect in the health sector and I think that that is coming out of South Auckland where we see a lot of clinical audits being undertaken, where we see scrutiny of peer groups by their own people, credentialling, a whole range of issues. And I don't think that we're seeing that generally across the whole of the sector.

> *Clinicians should be making decisions about clinical activities in how they treat patients and how they treat groups of patients. And managers should be worried about how to create the environment where that's achieved better.*

So then the CEO came in at a point where the relationship between the previous chair and the previous CEO and the clinicians had reached an impasse essentially. He came in with financial problems and with a polarised organisation involving two cultures having it out. His directive, determined behaviour suitable seems highly suitable for these early days of crisis management. It does not seem as suitable for settled times. This view is supported by Table 5. Health management will however always possess an element of crisis management, so it is not altogether unsuitable still. Nonetheless, it is the view of the author, that an integrated approach, involving more shared decision making, consultation, and collaboration is required now.

Some clinicians are cynical in speaking of the CEO but there is still a clear, albeit grudging, respect for the man, especially for the way that he has accomplished some large change efforts. So then the CEO appears to have been a very good at achieving ends and obtaining economic results. Along with this, and likely resulting from it, he seems very much a manager of the unitarist mold. All of this aligns itself to an economic approach to managing change amongst daily operations.

In talking to him, though, it is still clear that he recognises that there is a long way to go before clinicians and managers can be rightly viewed as joint partners in Canterbury Health Ltd, although he would probably prefer this. Common values and objectives would be a dream for the health system should it ever occur. Such integration is a long way away. A mixture of divergence exists even within the medical ranks, between the doctors and nurses, between clinicians themselves. Some pursue their own self-interests, some righteous, some not, others pursue negotiation and compromise. This is a reality. In this context, the CEO looms much less as coercive and obdurate and far more as well intentioned.

This is probably one of the biggest surprises given the innate constraints of his role. A single authority and loyalty structure does exist. This coincides with his preferred management style, being top-down and through hierarchy. The difference is that this is moderated, and accepted by the CEO as being moderated by, the pluralism of the health sector that he has worked in for years. One expects that he would not ask for or expect anything.

While the CEO does not seem to achieved anywhere near as much internally for the culture of Canterbury Health Ltd as he has done in terms of restructuring it within and without, dealing with conflict and industrial relations issues, and mediating the achievement of financial performance improvements, he has still demonstrated a considerable passion for its ongoing excellence and achievement. His relative success as a chief executive belies the importance of people with strong personalities to take outward leadership and management positions, especially within the public service. People-focussed sectors, such as education and health, rely heavily on enigmatic others at their forefront. Canterbury Health Ltd would not be what it is today if it were not for the unique dynamic that the CEO has brought to it.

> *I think that most of his successes have been external rather than internal, yup. And I think that some of the better consultation has resulted not from something that he's done but something to which he's been required to respond because I think some of the clinicians have said, 'Look, you know, listen to us' and the Stent inquiry changed the role of the CEO in the sense that, or at least changed the context in which the CEO was operating, because it proved that there were system failures which management was responsible for and that therefore management could be held to account whereas previously the inclination was to say if anything goes wrong it is the clinicians that are to fault in the system - that efficiencies that were introduced had no relevant organisational or clinical risks. Whereas once you showed that changing layers of nursing, and so on, do have clinical and other risks and implications for Canterbury Health Ltd then there's more to running a hospital than financial risk management then suddenly the CEO's role is a bit different.*
>
> *Anonymous respondent*

In conclusion, as the CEO leaves, it will be up to his non-interim successor to build on this external success but consolidating an internal climate and culture that is even far better unified, in so far as this is a possibility given the paradigmatically schismed differences between doctors, nurses, and managers. It is a bit of a tightrope walk as far as a manager is concerned to find a path between these two quite opposing ways of acting in the management of change. Both approaches can be utilised together but it requires a balancing act. How far one is done in all likelihood is probably moderated by how far the other is done - his successor will need wisdom and balance in this respect.

Problems with this approach

The CEO has been predominantly economic in his approach to the management of change. This has had both good and negative spinoffs for the organisation, in ways

already mentioned. Its focus has primarily been upon the short-medium term. This focus is consistent with the framework articulated by Table 1. This view is reflected in a respondent's comments within this study:

> *He's managed to get things done but a lot of those things will need re-doing and we know that things that get put together in health in New Zealand have to last. They don't get put down and rebuilt in five years time. We are stuck with them. I used to be out in an old terrapin building that was put on the back of the old hospital which was the department of surgery which was supposed to be there for three years and it stayed there for about seventeen or something. We've learned that what we get is what we get. We can't go back to them tomorrow and say 'this won't do'. We'll be stuck with it for years to come.*

The economic approach to organisational change was, of course, demonstrates some of the core values that underpinned the model of health restructuring that occurred through the last decade of the twentieth century. This model was especially prominent within New Zealand during the period, 1995-1996. This model, in some elements, has been palpably seen to fail. This is exemplified in the following clinician quote:

> *The hospital started going downhill quite badly in 1995-96 and they kicked off all the charge nurses because they changed that model. They decreased the numbers of teams and beds in the general medical wards so that there safety issues around the hospital and then people began to die. It became clearly documented that they were dying because of system failures and ultimately people failures because people fail when the system doesn't allow them to work properly.*

A contrast between the two approaches in this paper

One of the key differences between an economic and a developmental approach to the management of change can be expressed in the following way, as it was by a clinician in the context of this study:

> *That's the difference really between the ethic of a corporation and the ethic of a doctor ... we train all our juniors now to, if something goes wrong, go straight up, straight away and say 'sorry, we made a mistake here and this is not the outcome we wanted - we apologise to you and we'll put it right' ... But that's not the way that corporations see it, you see.*
>
> *They think that they'll protect their organisation by keeping things secret ... when [management after the 1993 reforms] came in here they had a notion that ... the running of a hospital was like running a tyre factory ... You've got to have a book to tell you how to do it. You've got to have a guideline to tell you how it to make it work. Management is now proud of the fact that they've got these great oceans of manuals now that tell us what we've got to do ...*

They wanted to make written rules for handling health [i.e. case management] ... this is only appropriate for handling a very small number of medical cases or conditions... Case management as a norm cannot be achieved. It bears no relationship to the treatment of acute cases and surgery, along with most other medical practice. Medicine, like education, is very difficult to, indeed, cannot be systematised. Economic approaches are like this - regimented, externally structured, output-centred, and not very flexible ...

They claim that they want us to get a higher throughput and then are obstructive in letting us achieve this end. There's a piece of equipment called an harmonic scapel which we use for cutting and dividing vessels, one of the real, genuine steps forward in the last few years ... I can put one extra patient on every list if I have [one of these] because I can save so much time. Now, over the course of a year that's millions [of dollars], millions ... It costs $30,000 and it took over 2 years to get ...

As far as [doctors are] concerned management is just there to help them do their job. Management isn't there to tell them what to do in terms of their independent clinical practice or how to do it or any of those things. It's just there to help them.

Our theory about [truly] empowering ... staff ... [e.g. nurses: 'a hard working, dedicated group'] ... you give them a bit of authority, you give them a bit of money to spend, show them that they're important to the organisation that they're in, that sort of thing, they'll work themselves to death ...

The way to run doctors is you train them well, pay them a reasonable salary, and let them get on with it, and then you audit them periodically and make sure they are doing alright ... they don't need interference, they are internally motivated, and they are capable of managing themselves, they do not need to be managed ... you can squeeze the life out of them by regulating them too much ...

There should be clinical input into management methods and decisions ... [We] need information to be able to make decisions on, that [we] don't get ... but yet we've got enormous, complicated managerial systems to achieve that ... can they think of a single way in which they help me do my job better?

Support is needed within a human profession, such as health, as much as the economic approach to management governance. Health after all entails people at least as much as non-human systems and structures. This is the essence of what is provided by a developmental approach and both what is inherent to the framework of Table 1 and lacking in Canterbury Health Ltd at the present.

A pragmatic assessment of the dominant approach

As already noted, Canterbury Health Ltd's corporate management, under the CEO's dominant approach to change and management, has been based around economic formulations and considerations. Whether this is a good or a bad thing remains very much a matter of perspective. Clinicians view it more in an optional and a negative light; management, more in an inescapable and positive one.

Whether you see the public hospital as a corporation or as a public service depends on political orientation, amongst other matters of value. Broader than any perspective, the reality of the situation is that it is both. The multiplicity of perspectives on the issue bears testimony to this subjective reality. The outside environment of society has changed significantly towards an increased business focus for reasons both of a macro-global and a local-institutional background. This reflects on the way that parts of the whole, that is hospital management, is viewed. This entails a pragmatic approach.

The CEO emits such a pragmatic perspective, despite the dominance of an economic approach to management. His role involves both sets of consideration and he appears to recognise. In practice one of these considerations, namely the economic, seems to predominate the other, that of organisational development. Maybe he feels that the former will lead to the latter. If so, he is wrong. This is not necessarily so. The two can be connected in practice but they are certainly not connected for innate reasons. They should be combined in practice nonetheless. This is the point of view of the author.

A pragmatic approach to change and its management is best expressed in this study through an anonymous clinician perspective:

> *Respondent: I can't conceive of how you can make this place work unless you do work with your management. It doesn't matter how bad they are. You're stuck with them. You've got to make it work. So you've got to get alongside them ... There were those of us who continued to try and work with them and those who didn't. Those who didn't ... didn't have a lot of line management responsibility and so it was easy enough for them to not ... They achieved in a way a lot of good. The Stent inquiry came through. They identified a lot of failings that were in Christchurch Hospital that weren't specifically related to the nature of [management] ... they were endemic within our health system because of the way we funded hospitals chronically and under-resourced them chronically and this what I'll come back to - we'll abuse*

ourselves if we keep going back to being ... masters of covering cracks ... no one should be a silent practitioner ... it's very easy later to turn round and point the finger and to blame rather than fix the systemic problem ...

Interviewer: Some clinicians would hold stronger views that yourself as to the relative merit of these changes and management and change management! You seem to have balance, co-operation and pragmatism. How has this come about?

R.: Tension ... is no use at all. No managers are out and out bastards. They are just people doing their job and caught up in the pressures of that job (maybe it is the job that is the bastard!). We [clinical directors and service managers] are equally responsible ...

A pragmatic view dictates a certain acceptance of a lack of consultation in local Canterbury Health Ltd institutional decision making due to the CEO's hands being constrained by decisions that are made at the political level. People need to understand that:

Inevitable decisions ... at the end of the day don't involve as much consultation as people would like due to the realities of processes in the real world ... People all see their own little view of the world as the proverbial blind men felt the elephant and a lot of us really have got our hands up his arsehole ... It is hard to see the totality of the situation all the time but things are not as bad as some make out and yet things can still be done better.

Canterbury Health Ltd management appears to realise the need for pragmatism, that the administration of all parties involved in the running of a health and hospital service involves a balancing act. Middle management in Canterbury Health Ltd certainly admitted it throughout interviews. They are aware that health workers are hugely important in an operational sense to the achievement and exceeding of targeted outcomes and organisational efficiency. Without explicitly stating such, it seemed that individuals judged clinicians and nurses as highly skilled staff and the human oil in the machine bureaucracy that Canterbury Health Ltd represents. They, as with clinicians, also demonstrated an understanding that "no never-ending pot of money" exists.

Economic ends are not wrong in themselves but that they need to be balanced with other considerations too. Economic factors are not the only factors that an organisation has or should consider. This seemingly obvious fact is sometimes and certainly not regularly conceded by managers.

A developmental approach was demonstrated and expressed by management in the following way:

> *[W]e want to be more values-driven as a management team at Christchurch Hospital ... and I know it links with what Corporate HQ wants. We're saying this is how we expect you to operate. And we know that we have to start small ... transmuting these values from above has been something that Gary Smith has been directly responsible for. He is the sort of leader that [senior management] has indicated [they] will be seeking to replace with a like-minded individual. Senior clinical staff have reiterated to [management] that that is the sort of leader that they are looking for in the future to take Christchurch Hospital to the next stage ... one has to remember that change is really slow and that any sort of cultural change where people are concerned is really slow. Although it's got to start from the top through role modelling and reflecting issues regarding values deep inside systems, it might five years for that sort of stuff to actually permeate the whole culture ... writing these values on the back of name badges is another small effort to bridge this change effort ...*

The realisation that more developmental, organisational work is required was both stated and accepted by management:

> *I think there is a general perception among the hospital staff, and I think it's probably right, that there are occasions when [senior management] could have obtained or done more by being less confrontational and HRM could perhaps have been more facilitative in conflict resolution than it has been. There was inevitable process following the dysfunctionality of the last regime where it would take several years to sort that out and that hasn't entirely been sorted out. There are still some people who say that [senior management's] style is still too confrontational, too authoritarian, for the new environment of the new Labour-led environment, and I think you can make a case either way.*
>
> *I think [senior management's] advocacy for Christchurch has been a plus. I think you're right in picking up the implications that you mentioned before. I think a lot of what he's done has been focussed around addressing the external threats and the external challenges and he's been very good on that front. Whereas that sort of style, which at times is a little pugilistic, is not the style that is going to achieve the internal changes.*
>
> *I still get a fairly widespread feeling that a significant group around the hospital feel that more genuine consultation, where you're actually working things through together, ... there's a far greater need for that. I remember somebody saying to me years ago, you don't manage doctors, you manage with doctors, and ... I don't think the trust is high enough to really make people feel they want to, that they really are proud of the place ... I think a lot of them are. I think they are proud of the work they do with patients but I don't think they are proud of Canterbury Health Ltd as an organisation to the extent that they could be if they felt that they were empowered to a greater extent.*

Emerging and potential dilemmas stemming from the application of this approach

Despite the ostensible successes of the management regime run by the CEO over his time at the helm of Canterbury Health Ltd thus far, the dominance of the economic approach to change and management (as defined by this paper) means that certain critical issues exist. These need to be addressed in order to better secure the ongoing cultural survival and bolster the solidity of the organisation as a whole. This remains despite the fact that management is optimistic about future directions and outcomes as far as Canterbury Health Ltd is concerned. As long ago as 1996, chief executives have expressed generally positive views highlighting the pleasure with which management views systems that focus on well-defined outputs and clearer directions (Malcolm, Barnett & Nuthall 1996). This optimism has not necessarily been well founded and possibly reflects the blinkers that management as a profession is sometimes obstructed.

Problems in Canterbury Health Ltd lie potentially reside or lie in shifts associated with behavioural, structural and cultural changes. Shifts in behaviour are associated with changed leadership patterns and style. Shifts in structure most notably involve aspects of the organisational performance management system. Issues relating to culture primarily involved the transmission of ideology within the change process.

1. Behaviour: leadership character

The character of management is an essential element in the achieving of effective organisational performance and development (Kaplan 1996; Cammock 2000). Personality and other individual-level characteristics influence character and character attributes in turn influence organisational behaviour and these performance outcomes. Above this, integrity is hugely important (Cammock 2000). The CEO's personal characteristics appeared appropriate for the crisis management required during his tenure. His directive manner does not however seem what is required in order to develop long-run stability and growth within Canterbury Health Ltd. As it is, he has already chosen to stand down and return to Australia. Some big questions face Canterbury Health's Ltd existing and future leadership. Succession management is not always easy and can be fraught with some difficulties relating to change management.

Who will replace the CEO? How will his management style be adopted, modelled or changed?

2. *Behaviour: power bases and alliances*

External collaboration and utilising information has been a feature of the CEO's management and has already been discussed in detail. The issue of exactly how much to share and with whom will continue to be a dominant question that health and hospital services in an age that has increasingly focussed on the benefits of cross-organisational alliances, trust or co-operation, and information sharing. The willingness to share has to be traded off against the risk of so doing, as economic theories imply. The merger with Healthlink South and Canterbury Health Ltd might prove problematic with respect board and management behaviour. At any rate, current alliances, such as those between Canterbury Health Ltd and Eldercare, Pegasus Medical Group, the Southern RHA and Healthlink South parties will need to be carefully managed in future for both the benefit of the organisation itself and the benefit of health recipients in the Canterbury region.

One optimistic comment on this note is that the past few years have definitely provided evidence that if healthcare providers worked together in a collaborative way, patient care improved. Lastly, as external collaboration has borne certain financial fruit in 2000 (e.g. the freeing up of funds through Pegasus's involvement with Canterbury Health Ltd) so internal collaboration needs to occur further. This is not the first time this suggestion has been made. Internal collaboration with clinicians and nurses needs to get better. Should this occur, Canterbury Health Ltd, as an institution, will be very strong indeed. This is a comment that has been endorsed by prominent people, arguing for altruistic co-operation and commercial considerations together taking precedence within hospital management.

3. *Structure: remuneration and performance management*

Implementing changes within the performance management systems of Canterbury Health Ltd was another management system area that transition during the period of the CEO's oversight. The addition of performance-related pay to this system was variously criticised and supported by members of the organisation during 1996-2000. The use of this element is consistent with an economic approach to the management

of change. Under the principles of agency theory, accurate accounting system information is a critical support to managing an organisation and change within an organisation. The principles of agency theory view individuals as actors that must be controlled. Accounting information provides a basis to regulate and maintain individual action upon. As authors have noted (Jacobs & Nilakant 1995; Jacobs 1995), the fixation of agency theory upon control, numbers and rules has been mirrored in the years of the 1990's inside the national health system by an increased preponderance upon budgeting, planning, contract formation, and the implementation of performance-related pay. Whether or not this is a beneficial thing within the health sector, only time will tell.

There are many opponents of and advocates for such remuneration systems. If the clear clinical opposition to this type of payment is anything to go by it is not likely to be a well-received, general method of rewarding these staff in the short-term, at least not until such methods become normative or institutionalised. This is so despite the fact that bonus systems of remuneration is very much in line with best practice findings in SHRM research and decentralised work environment and market structures. It is questionable however that these conditions apply to the health services being, as it is, a system that focuses on intangible care greater than external incentives. Cost minimisation is a focus of this system nonetheless and thus performance remains a key part of efficiency within it.

The motivational effect of managerial compensation within the health sector is arguable. Sir Douglas Black, a distinguished past president of the Royal College of Physicians, has argued cogently that the basis of a health service should be altruistic co-operation rather than something based purely on commercial considerations (Press, 1996). Bonuses derive from a strictly commercial culture. They give those who award them considerable authority over outcomes. The danger of bonuses is that they are used to reward managers for short-term efficiencies at the expense of good clinical practice.

We are unlikely to learn if this has been the case at Canterbury Health. That is not because the CEO has been a secretive manager. Indeed, he has generally been good for Christchurch Hospital, riven with strife under his predecessor. But the corporate model has meant that all our hospitals, transmuted from their old form supposedly to promote the public good, are now structured so that people know less about their internal workings than before. True, many have public-relations people dedicated to spreading 'positive' news, but that is not the same kind of knowledge as was available

when the media were able to report hospital board meetings. Today, unfortunately, considerations of privacy and commercial sensitivity stifle truly detailed inspection.

A focus on numbers is not always helpful. Indeed, a focus on simple mathematics is one of the biggest mistakes that managers can make. Improving performance with pay only can confuse the result of a process with the process itself. Not all people are motivated by extrinsic reward alone. The philosopher Alfred North Whitehead called it the 'fallacy of misplaced concreteness', to mistake the fever for the disease, the idol for the god. In his words, when people fall into this fallacy, they invariably make another, bigger mistake. They try to shoehorn people into their rigid, unreal scheme of the world, rather than using people to change the world. He has said, "The fact is one of the best ways to improve efficiency is to find out what pisses staff members off."

4. Culture: symbolic reorientation

Problems of implementation and change of organisational culture existed across the national sector in 1994 (Manzur & Lawrence 1994). This seems to parallel Canterbury Health Ltd's current position. The attempted transmission of ideology is a central feature of planned change processes. Lewinian theory about 'unfreezing' current habits, adopting desired habit states, and then refreezing these habits imparts a sense of this. Changing more than just the way that people act but the way they think as well encapsulates the notion of ideological change.

Canterbury Health Ltd has not been very successful in achieving internal results with the sort of uniformity that these models imply. It is not known to have attempted it in any sort of structured manner. Why not? Admittedly, historical factors make reduction of staff resistance a difficult task. Canterbury Health Ltd's management could much more purposefully pursue the effective utilisation of concerted efforts of people meeting, thinking, sharing and working together, with all of its synergistic implications. This could look to obtain, build, develop, and nurture organisational 'spirit'. This idea is explored a little further in the last section of this thesis. Human resource management's part in this process has already been touched on and is again implied in this area.

HRM has a part to play in shifting perceptions on culture. This facilitation requires a more of developmental approach from the top of the organisation down without neglecting to maintain fundamental bottom-line goals. Achieving it is in the long-term

interests of the organisation. It seems so simple - involving others, invoking participation, genuinely listening etc - hallmarks of standard approaches to successfully managing change. These have not occurred in Canterbury Health Ltd as much as you would think. It is illogical and bears badly on senior management. Clinicians do not seem to be seeking unilateral acceptance of their way but want a fair and thorough hearing; bilateral collaboration not competition; cooperation as against antagonism; compromise not avoiding or seceding.

HRM can play a greatly underestimated but vitally important part in promoting the understanding and respect of the differing perspectives inherent in the health context. HRM needs to be used strategically. Indeed, HRM and SHRM are flipsides to the same whole, that is the management of people to effective use within organisations. This use of the HRM function is essential to any development of any organisation, including Canterbury Health Ltd. However, operational HRM considerations need to be congruent with strategic HRM planning. Mutuality and alignment within HRM in Canterbury Health Ltd need to be goals over the next phase of Canterbury's Health Ltd future if the instilment of these positive values, to the ends already stated, is to occur.

Values can be a highly successful operating strategy that produces successful organisational functioning. The essence of making value-driven strategies work is management will and skill. It is skill to teach the organisation how to apply the values. It is will to make these strategies work and to talk about them as the hallmarks of how business is done every day. If a company talks about values, but does not inspect as to whether they are being followed, the company cannot make a values strategy succeed (Furash 1996). Canterbury Health Ltd has begun in its HRM section to do so and should continue to use values strategically across its whole organisation.

Cultural inertia needs to be overcome in order to gain additional system change and cultural development. This inertia has to be swept away in order to replace the residue of past archetypes and to achieve transformation, not sedimentation (Cooper, Hinings, Greenwood & Brown 1999; Sillince 1999).

5. Culture: internal and external communications

Excellent success has been achieved with respect to external communications in Canterbury Health Ltd. The employment, prior to the CEO's arrival, of a person with

experienced media involvement, Allanah James, as communications manager has helped achieve this. This person was employed to help produce positive feedback for the organisation. Proactive media relations has paid off, both in terms of positive press coverage and in ensuring that CHEs' views were represented even when the news was bad. This is consistent with a research study that has shown that quantity and favorability of press coverage is related to the input the organisation had into each story (Comrie 1997). Work now needs to be done on better communicating internally and building the cultural 'spirit' already referred to.

Concluding comments

So, the 'economic' approach to change described in an earlier section seems to best describe the approach toward change of Canterbury Health Ltd with respect to both changes in management at Christchurch Hospital and its wider operations. Characteristics of a developmental approach towards the management of change do not seem to be evident as much within Canterbury Health Ltd.

This has been illustrated in a number of the case studies within previous parts of the paper. It can also be clearly seen in the multidivisional structure used within Canterbury Health Ltd. This structure separates and removes the executives responsible for the destiny of the entire enterprise from the more routine operational activities. Through talking with divisional managers, strategy formulation and control in Canterbury Health Ltd is confirmed as the prime task of the top manager, the CEO, and strategic implementation as the responsibility of these divisional managers (Bateup, MacDonald, Magee, Smith). This separation is marked by the existence of corporate headquarters close to and connected to the operational hub of Christchurch Hospital. The premise that responsibility for control and consciousness must rest with the chief executive officer, "THE strategist" (Mintzberg 1990:176), reflects the individualism of the Classical, economic approach to the management of organisational change.

This economic approach could be symbolically viewed in the CEO's resignation. The fact that he was going to work within an arena highly focussed on information systems, his primary orientation toward numerical information and its use, and who replaced him for the interim, the finance manager, (Press, 21 November 2000). It would be problematic to suggest that this approach is never correct yet it is clearly short-sighted and less rich in utilising all the dynamics involved in organisational

contexts than other possible approaches. It appears not to be the most appropriate approach. This discussion extends throughout the remainder of this paper and will be explained further.

As already noted, Canterbury Health Ltd under the CEO's supervisory management has made some marked advances. Compared with its unstable and tenuous position in 1995, it is in far better stead now and the prospect of future improvement has undoubtedly improved. Certain problems remain, nonetheless. Paradoxically, the seeds of Canterbury Health Ltd's success as far as Christchurch Hospital is concerned could contain its ongoing failure or demise in certain respects.

People must always be viewed as people, not objects. Since 1985, New Zealand's health sector has faced a series of radical reforms that seem to have pleased no-one: consumers, the Government, hospital administrators, doctors or medical practitioners. Today an uneasy truce exists between those seeking further financial and structural reforms, a suspicious public, and a government wary of promoting further unpopular changes. History suggests that management is in many ways ambivalent to future directions. Management will accept the brief that they are given from above and oversee it to the best of their professional ability notwithstanding, in some cases, its actions being vested with self-interest. The overriding contention of this paper is that management should not remain passive in this regard and as regards the management of change in health. It must choose for itself which values are most important and help sculpt these future directions. This is management's joint role: leadership. The connections between these two aspects of management will be explored in the next section.

It has been demonstrated that change has been managed and has taken place within Canterbury Health Ltd as a result of both rationally driven 'economic' methods and 'developmental' methods built on planned incrementalism. Both are appropriate. Effective management seems to be about a combination of both passion and rationality, rationality being a construct of economic approaches and passion for people being a feature of developmental approaches. Change management needs to encompass both top-down (economic) approaches to change and centre or middle outward methods more synonymous with a developmental approach. This is in order to validate itself as, indeed, total change management involving the holism of all of organisational, group and individual-level transformation. Canterbury Health Ltd's senior management has probably not focussed enough upon this latter approach.

Hence, its efforts at the management of change, while partly successful (there is no question of this), have been and remain at best partial and more importantly have not touched or affected cultural aspects of the organisation's side enough. The continued use of developmental methods would be a powerful and successful tool in rectifying this imbalance. The rational pursuit of economic efficiency is necessary to a degree. Together with each other, economic and developmental approaches to managing change integrate and interlock in practice, thus complementing each other.

In response to key question of research ("what style is most appropriate to management of change in health?") the following statements can be made. An economic approach has worked in the short-term and might continue to do so in the short-term future. Crisis management might not however remain the order of the day. If and where stability occurs, a different type of approach is likely to be needed. Certainly, an integrated developmental-economic approach will be required for long-term growth and organisational, cultural development.

OD theorists have argued for a universally applicable leadership style that creates widespread organisational involvement in defining goals and implementing change (Golembiewski 1989; Schein 1985; Beer & Walton, 1990). This contrasts with writers, such as Salancik and Pfeffer (1978), whom have argued that directive and coercive approaches are often necessary to resolve conflicts of interest. In the case of Canterbury Health Ltd, both approaches can be seen to have been attempted. The latter has dominated and this demonstrates two aspects of the management of change.

Firstly, that directive and coercive approaches are profoundly easier and less subtle than the more applied or involved approaches of consultation and collaboration. Secondly, it bears out the inherently political nature of the system of human dynamic within Canterbury Health Ltd, particularly inside Christchurch Hospital. OD approaches are problematic within political organisations. The inherently political nature of health based on the competition for power of two professional groups, clinicians and managers, means that OD approaches to management, certainly to the management of change, are not as easy to apply. Without pre-empting the implications that are drawn later on, there appears to be a critical lesson here. Both collaborative or consultative (Type I and II) responses to management and directive or coercive (Type III and IV) approaches can be applied together. This is by no means easy or impossible but requires certain effort. In some cases, it might not be very practical but the conceptual framework already built in this paper suggests that, in

general, doing so and trying to do so will be profitable in a dual manner (i.e. with respect to both people and bottom-line ends).

This implication can be considered from another angle. Most of what managers deal with is based on a self-constructed view of reality. In seeking organisational results, managers pursue their own definition of success, based on their own values and interests, however, in order to survive they need to also recognise and accommodate the constructed environments of other powerful organisational stakeholders. To this end, managers need to try to be and, more importantly can be, both collaborative and directive at once within their thinking and, even paradoxically, within their actions. This is the essence of managerial 'balance'. It is the tightrope that the effective manager needs to regularly walk.

As James March (1981:564) has put it, a lot of "change in organisations results neither from extraordinary organisational processes or forces, nor from uncommon imagination, persistence or skill, but from relatively stable, routine processes that relate organisations to their environments [and internal systems]". March's is a processual view, more emergent than adaptive and planned in terms of epistemological basis. He goes on to say, "Change takes place because most of the time most people in an organisation do about what they are supposed to do . . . characterized by ordinary competence and minor initiative . . . [the organisation relying upon] stable procedures . . . for responding to economic, social, and political contexts" (564). The history of Canterbury Health Ltd over the period 1996-2000 is not different to this.

> *Interviewer: How has [change within Canterbury Health Ltd 1996-2000] come about? Has it been planned or enacted in some way? Has [senior management] done things that have led to this happening? Or has it rather more emerged as a product or consequence of time, even despite the way that he has acted? Has it been forced on him or has he forced change?*
>
> *Respondent: I think it's probably a little bit of both. I think the previous situation was such that we had reached a watershed and something had to happen. With the previous regime going, in a sense it was a bit like an organisational enema. It did clean the system out and there was a sense of vindication among the staff and so they in a sense felt that they had finally been heard by the powers that be. The political change of course was also important in that [it represented] a general acknowledgement that aspects of the reforms hadn't worked and that the political environment should be one that fosters more collaboration and so on ... the external environment improved things.*

Overwhelmingly, there remains a great need for better and more collaboration between clinicians and clinicians and clinicians and management. Co-operation and collaboration and not competition are the secret to a successfully functioning health institution of the complexity and size of Canterbury Health Ltd.

> *If you go back to the pre-commercial model, the changes that came about ... not all of them were bad ... Under the current way, there is accountability to the public, and ... [this has brought] efficiency because there is a focus on how we do things ... Our managers continue to work in the new environment where we do have accountability for volumes. We [clinicians] have to work together. They've got to sidle up to us and say 'Hey, how are we best to deal with [these medical issues]' ... and we have got to go to them and say 'Hey, we need some information to help us [in these medical issues]'. So, the era of co-operation is upon us.*
>
> *I believe we have very good people in our management but no manager can win if the clinicians don't want to work with them. From their perspective ... it doesn't matter if they hate doctors or not, pragmatics determine that they have to work with us otherwise they sink ... [it goes the other way too] if I really want to get the best for my patients then I have got to suck up to them ... but that's not necessary where you have the right personalities together, all recognising the common goal which is to provide the best we can for the patient with the resources we have - where's the fight there?*
>
> *Anonymous clinical respondents*

> If words of command are not clear and distinct, if orders are not thoroughly understood, then the general is to blame. But if his orders are clear, and the soldiers nevertheless disobey, then it is the fault of their officers.
>
> Sun Tzu, *The Art of War*

> If you can't have faith in what is held up to you for faith, you must find things to believe in yourself, for a life without faith in something is too narrow a space to live.
>
> George Edward Woodbury

> For consultants and management gurus, the soul is a slippery customer. On the one hand it may be dismissed completely. Many trainers and consultants maintain that the soul belongs at home or in church. But with little understanding of the essential link between the soul life and the creative gifts of their employees, hardheaded businesses listening so carefully to their hardheaded consultants may go the way of the incredibly hardheaded dinosaurs. For all their emphasis on the bottom line, they are adrift from the very engine at the center of a person's creative application to work.
>
> David Whyte, *The Heart Aroused* (1994), 16

PART IV WIDER ASPECTS OF THE MANAGEMENT OF CHANGE

IMPLICATIONS AND RECOMMENDATIONS

The process of change from the inside out is seen in Christchurch Hospital's influence on change across the organisation. The way that it responds to change initiatives directly affect other institutions within the health and hospital service due to its size and influence on the remainder.

Change will continue to occur within Canterbury Health Ltd as a result of its dynamic environment and internal context. The latter certainly needs more change to occur within it for the benefit of the organisation as a whole. However, this type of change takes a long time to transfuse through culture. It cannot be produced by anything but

an inside-out (developmental) approach. A top-down institution of change is required quite often as a trigger for organisational change but that which actually manages that change and is profoundly more meaningful in terms of producing that change is this sort of inside-out change management process. The basis of this process is entailed within the post-structural principle of changing those around you and letting change permeate outside those walls in a cellular fashion. These tactics are revolutionary and occur on a small-scale involving the individual. This highlights the importance of the individual in the selection and recruitment process.

Change of this sort is enacted on the basis of the variable of the individual. Individual clinicians and managers can indirectly influence the behaviour of the group. Again, this highlights the importance of the individual in the selection and recruitment process. Future employee selection decisions are hugely important for cultural change. Who is selected needs to display values that are congruent with the desired outcomes for the organisation in the long run.

The metaphor of a bridge can be used for the way that economic and developmental approaches to change management can interconnect. As opposites, they dovetail one into the other and can be utilised in synchronous manners if management can understand how to juggle their different and sometimes competing demands. What each approach lacks, the other supplies. An economic approach is detailed, analytical, tends to be transactional and concerned with efficiency. A developmental approach is group-based, creative, tends to be transformationally oriented, and concerned with effectiveness. What each approach lacks, the other supplies. They go together and link with the other like Siamese twins, without the support of the other each remains weak or fails. When only one approach is used, a perpetual cycle of kinesis to stasis to kinesis is a likely result. When both approaches are used together, system and organisation transformation is a likely result. Both approaches can be transformational. Taken together, both are transformational. If used together, both efficiency in the short-term and effectiveness in the long-term can be achieved and nurtured. Each approach is a counterweight to the other.

In the transition of managing the movement to a changed organisational state that is required by change management, the metaphor of a bridge provides a means of better understanding how the two quite different, in many ways apparently opposite, approaches can be synthesised and unified within the one construct. For an economic approach can provide the structure within which change can occur efficiently due to its focus upon the whole system of throughput and output. A developmental approach

operating on the level of the subset of the system can then be overlaid on or transposed over this structure, as and when management allows for this. The metaphor of a bridge illustrates this.

Infrastructure needs to be built. This is the part that an economic approach can play. It can provide the struts and supports that will help provide the ability to shift or transport people through a developmental approach. Management's role involves making the vision reality. Economic planning is critical. It then needs to be incorporated into vision. This is where rationality meets passion. Once built, this infrastructure can then facilitate the movement of traffic from one place to the other. This is the ultimate end of change management, procuring the transfer of people from one organisational position to a new and desired organisational state.

In this extended metaphor, the traffic represents the continuous and dynamic nature of organisational cultural context. It does, however, need to be pointed out that the shift to organisational learning or adjustment on a sophisticated cultural or developmental level requires more than just the structure of a rules-based, economic system approach. Nonetheless, this can be the starting point.

Equal place needs to be made for both economic strategy and cultural soul. Cammock (1999) draws this distinction between the managerial sub-tasks of strictly management and leadership. Breakthrough and fulfillment come through the meeting of these two parts soul (Whyte 1994:177).

Having an awareness of the complex nature of leadership and management and consciously adapting our approach to each situation is the role of the effective manager. The future orientation of leadership and the pragmatic, day-to-day, focus of management are equally important aspects of this role. Strong management must support vision. Organisation and control will fail without engaging subserviants and colleagues in a common purpose. Leadership will not emerge without a social context and will only be successful if the processes of management and leadership are blended together. The individual who practices this amalgamation can truly be described as a visionary manager. Such an aim needs to be the aspiration of all managers that practice in the health sector.

The CEO did demonstrate a planned pulling back from the situation to allow for more management at an institutional level in the form of general managers in conjunction with elected clinical representatives. This type of developmental approach to change

management needs to be ongoing in terms of looking to improve collegial relations. Developmental methods, involving local management (especially human resources) and specialists brought in from the outside, may well prove useful in helping to overcome interpersonal differences between management, medical groups, especially 'pockets' within the latter. Who or what governance mechanism succeeds the CEO will be critical in determining the actual success experienced in future years.

The implications of this section carry on this thread of discussion and revolve around the current nature of change theory, the actual practice of change and its leadership, the issue of transformative change, the values of health management, and close with some final thoughts on cultural development.

Implications and recommendations for the management of change

The process of change and its application to organisational theory

The contribution of the CEO and his management team towards enacting productive change within Canterbury Health Ltd illustrates the relevance of some angles of debate within contemporary organisational theory. This group have collectively exhibited some manifestation of positive managerially driven change. That much is clear. The actions of managers have influenced beneficial organisational outcomes. Purposeful and positive adaptive change has occurred in Canterbury Health Ltd due to this former group's strategic choice and implementation which has been aimed at improving organisational performance. This is quite in accord with an approach that has its basis in structural contingency theory. Planned, purposeful and positive managerial action is its essence.

Some of the change that has occurred could also, quite reasonably, be ascribed to an institutional compliance with the demands of statutory legality and methods involving benchmarking. Thus, coercive and mimetic isomorphism can be seen. Institutional theory is certainly a viable lens to view some of Canterbury Health Ltd's development with. The constituents of state and competitor do provide organisational impetus for change and growth in practice.

Pressures from regulatory agencies, such as the state, quasi-state agencies, and professional agencies, has no doubt contributed to the growth in importance of protocol writing and implementation within Canterbury Health Ltd over the last few

years. The pressure to make explicit the procedures and processes used in everyday medical tasks has come from outside of the health institution itself. This pressure has come to fall on human resource management to produce this standardised protocol and on line clinical staff to oversee adherence to this protocol. The process to comply with regulatory agency pressure has been reinforced by general social expectation and the actions of other leading organisations. The rationale used by management to explain why this institutional conformity is necessary is typically restricted to reducing task uncertainty and the risk of litigation. Coercive and normative isomorphism explains this response. An archetype for this type of change can be seen to have permeated Canterbury Health Ltd's individual institutions through the continued pressure for ISO accreditation. The problem with this theory, like many popular approaches, is that it is, at best, a partial explanation of why organisations operate and change as they do in terms of all aspects of change.

The same can be said of the theoretical approach of organisational economics. To some degree, applications of this theory can be perceived in managerial actions and decisions. It does not, however, provide a complete explanation for the behaviour of people as managers within organisations. Donaldson (1995) unequivocally supports this view. Organisational economics is a theory that is applicable especially at the individual level. Contingency theory and institutional theory apply far more at the strategic or organisational level. This contrasts further still with a theory such as population ecology theory which applies at the even broader environmental level. The application of these theories brings the theory to life. There is nothing as practical as a good theory. In Canterbury Health Ltd, these theories are given body and life.

On the matter of organisational change, change can be seen to take a deterministic fashion contrary to the optimistic, purposive view of structural contingency theory. Voluntaristic individual action certainly influences incremental change but wider and collective forces shape change in reality. This is akin to a processual view of organisational change in which context is highly determinant.

managerial actions
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forces of change
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The scope and pace of change can then be understood through a contextual mirror. Management has been restricted as to the degree of change that it could make due, in a large manner, to disagreement and disharmony with clinical staff. This resistance was

not unable to be reduced by management tactics or techniques. Systems of people are not as able to be controlled as classically wrested strategic theory considers possible. It is not that unable to be controlled as evolutionary strategic theory suggests either. The real answer where large systems of people are involved, such as in hospitals, lies in systemic and processual approaches to understanding change, as it occurs within a strategic sense. All this can be seen in the experience of people within Canterbury Health Ltd over the last four years.

> *I think that the position of Canterbury Health Ltd and Healthlink South is so much better than it was four years ago. Just chalk and cheese. Light years away ... In reality I think that most people would decidedly recognise a huge amount of change. It's like taking a picture of a moving train at a station. You can't tell where its come from and how fast its going. You've just got a single frame. You've got to look at health in the context of where it's been and where it's headed ... A mixture of incremental change and external process has caused transformation over a relatively short time ... Over the last four years, I think health in NZ has been absolutely transformed. You think about what it was like four years ago and think about what it is like today ... We've had some high profile issues around but that's not what the story of the last four years has really been about.*

Managers do not know everything and are not rationally infallible. Classical theories of strategy assume more to the contrary. Management as a function remains imperfect. Semi-closed system thinking based on rules, processes and procedures is not enough in charting organisational progress through the often deep and unknown waters of change. Vision is needed, along with openness, trust, and acceptance of the requirement of dependence upon others and the fact that not everything is either knowable or controllable. This balances against quite natural management tendencies and gives a much broader outlook by incorporating an understanding of these vagaries. This is a part of the envisioning that leadership is built upon and which perceives truth as being greater than the individual's limited self and appreciation. Both management and leadership are required in the process of overseeing organisational change.

Action learning has undoubtedly occurred within Canterbury Health Ltd with adaptations being made by its participants working on and evaluating their own learning. This is a powerful, but often slow and painful process, which changes the barriers to questioning that which has established itself within the processual inner-world of participant-managers and the mainly procedural outer-world of their organisations. This illiterates how processes of change do not always occur as a result of planned effort. There is a two-way relationship of learning that has existed between

clinicians and managers. This two-way effect is necessary for meaningful, organisational developmental change to occur. The testimony of a manager pays credence to this:

> *Although this is so, as a manager, you are always doing both. You are driving but you are also aware that you are going to be a part of it as well. Managers are receiving change as well as driving it. This is a critical part of the change process.*

In this light, during the change management process various groups can find that they are simultaneously all or a combination of envisioner, implementer and recipient.

The leadership of change

As already mentioned, the style of leadership in a health and hospital service is determined to a considerable extent by the type of structure of a health system and, in particular, by its degree of centralisation or decentralization. Despite this, it is the contention of this section of writing that the leadership-management of New Zealand health and hospital services is more importantly dependent on the character and personality of the respective leaders-managers of these institutions themselves. The style of leadership can then be changed irrespective of the structure of the wider health system, indeed, it must. To the end of setting a positive example, it is believed that the CEO of Middlemore Hospital represents such.

Goss, Pascale and Athos (1993) argue that successful leaders create a context that facilitates discontinuous change. The CEO helped to achieve this. At the moment, across the country, leadership more often than not seems to consist simply of crisis management. This does not represent leadership in its fullest sense. A principal function of leadership should be to initiate and sustain dialogue between individual actors and sectors, including organised communities and the general public. The CEO appeared to do this.

There exists also the need within the national health service for leadership that unites and works with others. In health, this need is reflected in the need for more multisectoral collaboration. Again, the CEO should be commended for his efforts in achieving what he did in this matter. As far as multisectoral collaboration goes, progress is only possible if conflicts and disagreements are aired and thoroughly debated and incentive structures properly developed. Economic arguments showing the benefits of investments in health might be used in this too to stimulate other

sectors, particularly political, and promote collaboration. On the local level, different types of consultation are required. Between national and local levels, the interchange of managers and planners between sectors can only be beneficial, in that it provides additional insights and facilitates collaboration. Also, present financing systems often militate against multisectoral collaboration because of their complexity and rigidity. One way of facilitating multisectoral collaboration might be to introduce joint funding arrangements. The consideration of such options will be part of the function of the new administrators responsible for the oversight of the new national health system.

Organisation members often experience conflict when two powerful forces oppose each other. Members feel trapped in fixed and rigid positions. When change finally does occur it can be highly disruptive and jolting, devastating people and leaving them insecure, apathetic and distrustful (Olson 1990). Again, true leadership requires overcoming this and amalgamating disparate groups.

Joint collaboration between clinicians and management is needed more and more, breaking down perceptual barriers, promoting understanding and respect of different perspectives. In accomplishing this end, Habermas (1970) seems right. Valid knowledge can only emerge from a situation of open, free, and uninterrupted dialogue. Questions of truth are inextricably bound up with political problems of freedom to communicate and to exchange ideas (Habermas 1963, 1970). This has significant implications for achieving organisational transformation (Giri 1998). People need to be free to communicate honestly and need to feel heard.

The CEO managed in a 'front-on' manner. This is his individual personality. It aided problem solving and problem solving is, of course, a key management activity. As the earlier discussion of situational considerations has already demonstrated a direct management style is not, of itself, a bad or misapplied thing. However, such a style can apparently overlook developmental aspects and the needs of the most obvious internal stakeholders of the organisation, the staff. An apparently glaring fault that management has made in the last five years has been failing to capitalise on the opportunity to develop markedly better and altogether *deeper* relationships with clinicians, as a whole. This needs to be worked upon by both parties.

On some issues there has been an abundance of time to, if the opportunity was seized by management, develop these relationships. To use Dunphy and Stace's model, collaborative leadership has been possible. Typically, however, a directive approach has remained the normal approach that is taken, especially by senior management

within Christchurch Hospital. On other issues, time has remained short and of the essence, hence, still according to this framework, an approach of the latter style has been more appropriate.

Organisations are created for the purpose of promoting individual and group benefits. Organisation development is a strategy utilized by organisations that wish to establish a climate for and implement interventions and processes to change. The body of an organisation is its corpus, and the spirit is its artificial system. The corpus consists of individuals with common goals or backgrounds, and the artificial system is made up of their ideas, assumptions, beliefs, and values. Changing the corpus entails hiring, firing, and rearranging. Changing the artificial system requires a shifting of ideas, assumptions, values, and beliefs - a relatively long-term proposition that requires effort, risk, and anguish. Personal preparation of the organisational physician (leaders and managers) is one of the greatest factors in successful change (Nielsen, Saccoman & Nykodom 1995).

In these respects, and in light of the CEO's resignation, Canterbury Health Ltd needs more of the leadership qualities, claimed by local media, to have been exuded by Jane Parfitt. To it, she was able to bridge the gap between senior management and doctors and nurses working in public hospitals. As well as being a very good quality manager she also appreciated the value of senior doctors and nurses (Press, 1 August 2000).

Cammock (2000:13) describes the "almost totemistic quality" that managers now possess in occidental society whereby they are ascribed prestige commensurate to the large responsibility that they accept by virtue of definition of the roles they undertake. Management is distinguished by a superordinate responsibility in the organisational context to produce performance results. To this end, responsibility and accountability go hand in hand. Efficiency and effectiveness comprise meeting performance objectives. The manager is responsible for this and, in the event of a failure to achieve these objectives, is primarily targeted as, again, the one that is responsible for this. The manager's role is not unlike the role of the modern sports coach and 'coaching' is indeed a part of the manager's role. Today's essential view of management is that a group or organisation can only be as good as its head management and/or leadership. Attribution for why outcomes occur at the group or organisational level is directly connected with that at the individual level of the manager qua leader.

True, passionate leadership and ordinary, efficient management shares a certain amount of ground. This overlap can be described as existing courtesy of the partially

reciprocal relationship that the two share. That is to simply say, management often demands highly strong leadership skills and leadership, to be effective, requires or depends upon the assistance of a fairly wide degree of management expertise.

However, leadership is marked by a less passive and administrative style, compared with the task of management. It is useful to draw the distinction between the two further by referring to a series of contrasts. It is active in the sense that can be seen to purposefully shape destiny rather than accommodating, compromising with, or merely accepting change in either the internal or external environment. It is less constrained by order or method and contained by what can be considered as the rationality of the mind than it is both liberated and set free by spontaneity and a deep, inner, heartfelt sense of what must be achieved. Leadership embraces and raises passion. Management occupies itself with order and sense.

Both management and leaders involve working through and with people. A leader's life is marked by a resonance of expressed vision or mission with actions and word. A manager's life is not necessarily so. Management can sometimes be drawn to separate or disassociate its 'head' from the 'heart' of leadership. The head refers to the centre of cognitive, strategic thinking; the heart refers to the people side of the operational equation. Leadership similarly can lack the head but have the heart. Inspiring leadership requires both. The disassociation of head from heart has characterised the New Zealand health system over the last decade with many incidents occurring which can be viewed as involving the dispassionate quality of sheer bottom-line rationality.

Good examples of this exist in the area of patient and staff treatment. At its most absurd, is was seen at the highest level in the way in which Jane Parfitt, CEO of Healthlink South, quit after finding out about her own board's decision to merge with Canterbury Health Ltd only after the event was exposed in the media. This action is not untypical of management acting unbridled and without the human restraint and sensitivity of leadership. The two simply have to go together in the management of organisational change. The point is this that both must be present. Both must be activated and engaged. Both are complementary to the process of decisive and effective organisational functioning.

Management is good, most appropriate, in stable and settled times. Leadership is most needed in times of dynamic change. It is somewhat ironic, therefore, that sterile management alone has characterised most the manner in which the health system has been managed for the last ten change-permeated, change-riddled years. Maybe, and

more telling, this might reflect the limitations of the people involved in management over this period to actually enact leadership within themselves and transmit this to the organisations of health for which they have had oversight. That is not to say that leaders have not variously appeared upon this landscape over this time. Rather, that they have become lost in the system or, all too often, frustrated by it. Such was the case with Parfitt.

Leaders need to care for the spirit. Leaders need to prepare their people, develop them, challenge them, encourage them, and touch them with their vision and the passion for that vision. Leaders know that if they do these things many of the management concerns of programs, balanced budgets and profits will result. Companies need leaders who understand that the most important contribution they make is the care of the spirit of their people and their organisation.

Structural approaches to change present only part of the solution to a complex dilemma. In addition, management needs to address the role of emotion, and spirituality in particular, in the change process. In this sense, spirituality should be seen as a kind of positive emotion that serves as the thread connecting the non-rational dimensions of human behaviour that are so integral to implementing change is developed. Dehler & Welsh (1994) have built work on this thought and extended the Porras and Silvers (1991) model, which distinguishes organisational transformation from organisational development as intervention strategies, by incorporating the emotional aspects of critical variables into the organisational transformation approach.

Contingency-based thinking upon the subject of leadership demonstrates the tight inter-connection of these two roles based on the situation at hand. Whereas leadership draws its power on expert and personal sources, management derives its strength from positional and formal bases. The need for the use of each depends on an array of factors. Not all of these have probably yet been identified and explicated. Vroom & Yetton (1973) and Hersey & Blanchard (1982) have identified some however. Depth of relationship, the type of task involved, time at hand available, imminence of decision-making, importance of decision-making – these are some of the factors that have been identified thus far in the management literature. Leadership is best suited within high relationships, where the development of that relationship is an important priority. Management is better used when the relationship is of a lower nature, where time is constrained.

Drawing from Hersey & Blanchard's (1982) model, leadership could be seen to be primarily based around a care for people. Management is more focussed upon a care for task. In Vroom & Yetton's (1973) model, this divergence could be seen to be represented by a comparison of leadership having the concern for decision acceptance and management having a concern for decision quality. These bipolar views, just as the two faces of economic and developmental approaches to planned change do, complement each other. Once integrated, leadership and management distinctions fuse into a merged approach to organisational administration and governance that possesses both increased sophistication and power than either upon their own.

Leadership should therefore be perceived of as more participative and facilitative than management which is more autocratic and directive, sometimes coercive, by nature. The readiness of application of such 'management' style tactics by senior management within Canterbury Health Ltd's experience of the last few years may well reflect the pressures of working in that industry. Time is often short for decisions to be made and implemented within. This time does not necessarily allow for the development of organisational relationships to be regarded as a priority.

And yet the level of staff commitment possible in the health system remains high. Health professionals seem to be highly dedicated people with very benevolent, giving, human-orientated natures. 'What might be possible with such people if their commitment was engaged as fully as possible?' is a rhetorical question that might well be posed in public for positive effect. This potential is only realisable by a leadership decision by management to invest in the non-physical capital and processes of their health organisations. The positive scope of such possibilities remains endless.

Over the last few decades, managerial rationality has taken residence and dominated in Western countries, certainly the United States, Britain, Australia and New Zealand. Much of this has been driven from the United States and evidence of the rationality has been manifest in the language and action of central government, as already noted. Managerial features, such as accountability and performance management, have slowly been universalised and institutionalised across socio-eco-political boundaries within these countries. The extent to which this has filtered down through society is recognisable at even the most basic levels. Its impact has been strong in both business and human professions (i.e. health and education). Indeed, as a result of this ideological drive, the latter has been seen by some commentators to be becoming a business *rather* than a human profession. In this context, strong leadership is required. The essence of this leadership needs to be service.

Typically, there is a mismatch between the management style favoured by policy-makers and reformers and the necessary flexibility required in the skill mix and organisation of health service work. High-trust relations lie at the heart of clinicians whereas the new managerialism appears to be based on the expectation of low-trust relations. For this reason, health service managers have to serve as educators, communicators, and comforters to divergent constituencies. To do this, a balance needs to be reestablished between short-term goals and long-term vision.

Towards a more genuine transformative change: taking a third path

Table 3 suggested a conglomerative approach to change management involving both economic and developmental approaches. This combination represents what this section refers to as the 'third path'. It is not a new idea. Writers in quite different contexts have suggested the same notion for some time (Cammock 2000; Whyte 1994). It is rarely applied however. The reiteration of this idea, not groundbreaking in itself but remonstrative in reminding people of its importance, is the major thrust of this extended paper.

OD-based approaches to change have not been synonymous with transformative change (Porras & Silvers 1991). There is no reason, however, to exclude OD methods from being a part of the organisational 'mix' that is required in achieving transformation. OD has particularly been applied in the past and seems best suited to stable environmental conditions. It certainly provides stability to an organisation. Economic management styles are more characteristic, however, of an unstable strategic environment. They too can add to organisational insecurity with the fear of restructuring etc.

An OD approach to organisational change is well suited also to an innovative, non-bureaucratic organisational structure. In bureaucratic structures, OD can develop a heightened sense of what relationships members prefer as people and makes groups aware of a clearer sense of the gap between these preferences and what organisational structures imply, encourage or even coercively demand. As such, OD can have quite a destructive effect, one contrary to its intention. It can heighten frustration about work life and deepen despair regarding the inability to make meaningful change. For this reason, hospitals can be difficult places to implement OD methods. Today, however,

such organisational structures are increasingly being turned away from. OD tools are and remain as sources of great potential value.

Transformation involves totality. It implies large paradigms and large paradigm shifts. Breaking mental models is rarely easy. Covey (1994) speaks about what is required for paradigm shifting. In the terms that this paper has used, leadership is required as the primary influence in this process, supported or followed up by management. The former relies on character. The latter relies on personality, to refer to Covey's terms (1994:12). Private and individual victory precedes collective, public success. The implications of this point seem clear for organisations. People of integrity are needed. Individuals are the architects of a successful organisation and individuals are responsible for choosing how they act. This sense of personal mission underpins the plethora of eclectic references used within this paper.

The problem which managers face during organisational change is how to motivate people to see it as desirable and necessary so that they become willing participants rather than saboteurs (Sillince 1999). Motivating change, especially during the early stage of the organisational change process, requires the communication of appeals for support and statements of goals or ideals. It is here that people need emotion-based responses towards change, in particular (Dehler & Welsh 1994). This is so for the reason that affecting behavioural change and not just cognitive change in the first instance is required in order to generate the action of people towards a new transcendent, improved and transformed fashion.

The past decade has witnessed a number of interesting shifts in the way people think about organisations. One of the most curious is the way in which much of the new thinking is antithetical to mechanistic and rationalistic theories that have historically dominated organisation and management studies. Organisation and social theorists have noted that, historically, organisations have been conceived of as machines (Burrell & Morgan 1979). Regularity, predictability, order, and efficiency were the main features organisations were supposed to exhibit and, indeed, acquiring these features was taken to be the most important reason for formally organising social action (Weber 1947).

There are signs, however, that this mechanistic projection's influence is diminishing. Looking across the overall pattern of developments, one can see that the language now used to talk about organisation and management is significantly less mechanistic than before. Recent developments in most sub-fields of management studies have in

common a move away from the Newtonian style towards a reconceptualization of their subject matter in terms of meaning, interpretation, ambiguity, conflict, context-dependence, and reflexivity (Weick 1979).

One of the most pervasive developments has been the understanding of organisations as cultures and as political arenas (Pfeffer 1981). Whereas earlier theorists focused predominantly on what they thought were the context-free aspects of organisations (e.g. structure, environment and technology), in more recent times there has been a growing appreciation of the language-mediated texture of organising and of the consequent need to understand questions of meaning and power (Smircich & Morgan 1982; Weick 1979). Such a conceptual shift is vividly brought into focus by contrasting Weber's description of 'entzauberung' (loss of magic) that accompanies the bureaucratization of social life, against the concern of some contemporary researchers with strengthening the 'spiritual dimension' of organisations (Bolman & Deal 1995; Frost & Egri 1994; Bartunek & Moch 1987).

In strategic management, influential theorists now see strategy not as the outcome of a rational process of planning, but as whatever emerges from a process of creative, often playful, acting (Whittington 1993; Wilson 1992). In operations research, while the traditional concern with optimization has not disappeared, leading scholars have persistently underscored the importance of learning (and therefore the impossibility of arriving at truly optimal decisions), interpretation, and systemic wholeness. To a large extent, problems are seen not as objectively given entities, which can be resolved by the mathematical techniques of the experts, but as subjective constructions dependent on the understandings of those who experience them. Likewise, in accounting, there has been a considerable interest in how accounting provides a language not for representing reality, as it was traditionally thought, but for constituting it.

What is striking about these conceptual shifts is the extent to which new approaches to management theorizing appear as the antitheses of the views that preceded them. Where earlier researchers saw clarity, researchers now see ambiguity; where there was singularity, now there is diversity: where earlier theorists searched for regularities and general theories, many now discover idiosyncrasies and particularities. This awareness needs to be understood by managers in practice.

The lucid rhetoric of Canterbury Health Ltd mission as involving inter-organisational consultation (and its implied co-operation and compromise) needs to be translated into regular action in order to change cultural images and challenge cultural habits based

on a history division between management and clinical staff. This will be what is required in order for truly transformative change to take place within the organisational psyche. This, coupled with staff members alike acting in a manner that is congruent with stated organisational purpose, is greatly needed within Canterbury health Ltd. At the moment, there is little sign of any change apart from that which is adaptive. Of course, this begs the question, 'Are people's hearts in their work?'.

Each of economic and developmental approaches to change is needed at various times in the management of change process. Both can be used in the change process but ideally both will be present for reasons including pragmatism and humanistic welfare aspects. Both must be activated and engaged. Both are complementary to the process of decisive and effective organisational functioning. Because the whole system is shifting toward a new organisational reality, the approach adopted toward making change must reflect the breadth of the change process. In doing this, a focus on the impact on resources and people of the change process and the personal leadership in it must not be neglected.

Implications and recommendations for the management of health

These days, more than ever, appearance suffices for reality. This is a manifestation of the superficiality that has crept into our personal perceptual screens with the dominance of the market and marketing driven machine that now undergirds a Western, consumerist, business-based, and economic approach to social systems. Having said this, the CEO's employment relations on the whole, pragmatically (note this, not ideologically, which would be easier) considered by the author, appear to be good, certainly better than worse, and appropriate much of the time. His approach to change management has been ideal to meeting the crises that he initially faced and has altered since to deal with a more stable internal and external environment. It is in this latter regard alone that any criticism of his approach to change management has been directed. It needs to be more developmental. There is still much ground to work on and yet, positively, much more scope and cooperative potential within staff ranks to work with still.

Head over heart: mission, values and the health system

> *In my opinion ... you should advocate what is best for the patient and the whole country ... you should say [to management] 'Here are the different requirements. Are*

> *we being fair to workers to make them realise their best potential etc?' If it's clear that they're not being fair then you say to government or to the board 'Look, in order to pay what is fair then we need an increase in the budget'. They say from above, 'No, you're not getting an increase'. Therefore, the managers have to be unfair. They cannot actually be fair employers. If it's clearly unfair what they are doing to their workers then it is an inequitable system, an unfair system, and ultimately an unworkable system because if a worker is pissed off they are not going to do the best by what the manager perceives to be the best for the hospital. They may continue to do what they feel to be best for their patients and themselves but they are not going to their best overall. We should be working together, not against each other.*

It is a feature of the modern day that achievement, success and development, are very rarely measured in anything other than outward results. People living in the 'civilised', metropolitan regions of the world tend to be characterised by a functionalist mentality that focuses on producing output for financial gain as opposed to viewing products of labour as ends in themselves. This ethic is inherited from birth it would seem and reinforced by subtle psychological processes throughout adult development. The existence of a consumer society necessitates this ethic. Such an attitude needs to exist at some level in order to survive. The degree that one embraces it and uses it as justification for action is, however, a relative matter.

The case of public health is an area that exemplifies where the line should be drawn between these two types of thinking. It is the belief of the author that the latter perspective should be adopted within its management. That is to say, the products of health management, namely healthy human beings, should be recognised as ends in themselves rather than vehicles or apparatus for the potential creation of financial gain. The contention has traditionally been first and foremost within definitions of exactly what it is that health aims to deliver. Also, this contention is not so much to allow for waste as to provide a full service. It is a matter of priority and about the ordering of economic issue after the far greater issue of human importance.

Discussion of this sort raises the topic of values. Words like values and soul are almost guaranteed to make most New Zealand CEO's squirm. Yet, with international business thinking no longer totally preoccupied with the bottom line, they are part of a new vocabulary that astute chief executives would be unwise to ignore (Grant 1998). Discussion of values is a highly sensitive area. Discussion of values therefore rarely takes place. Here, though, values are essential to be understood and central to the manner in which health is administered. The existence of certain positive values is also extremely important for the future. Let it be demonstrated.

Values are most important for the survival of the operation of organisations. They contain or possess a lasting quality. This is the reason why many organisations try to craft notions based around values into statements, phrases or symbols that are attempted to be engrained within the organisational psyche as it is manifest in the actions of the individuals that work within it. Mission statements are centrally prepossessed with values and this idea of 'values-creation'. This need for values or enduring symbiotic qualities is particularly so in today's dynamic external environment. Probably the only way that it is possible for an organisation to remain assured in the future is to produce and then maintain lasting values that will survive despite structural and other more superficial change. The kernel that defines what an organisation is about and what it will be remembered for in days ahead is comprised by the sentiment of values.

Positive values are not easy to create or maintain. They are also quite simple to achieve – an organisation's members need only choose to use them. Such values are expressed through showing care for others, being brave, taking risks for the sake of achieving a greater good, demonstrating and relying on vision, spirit and intuition, and trusting other people. When fused with bottom-line, control and structural considerations, along with the alignment of paths to these combined goals, then organisational harmony is more likely to be in evidence and the creation of lasting values occur. This is the effect of complementarity. Opposites, taken together, produce balance. Values, therefore, can help produce balance or peace but their use requires an organic and integrated approach. Balance and peace are much-needed attributes in these times of 'permanent white water'[1].

As already noted, these days are marked by a preoccupation within management upon the bottom-line, structure, goals and control. These ends attract much influence and most of the time, attention and resources at the manager's disposal. It has become a sign of the times at this present stage of human development. One thing is certain. It needs to be balanced, in the way so described, with values such as caring and trust and this for one of two possible major motivations. One reason has already been alluded to through the mention of organisational survival. The crafting and reliance on deep, positive organisational values can be instrumental in producing highly effective organisational results. The prime reason for utilising these values, however, is not a

[1] Source anonymous.

question of modal efficacy. This remains because on a human level it is best and most appropriate - the only right way – as an end value, as an end in itself

It might seem too simplistic or too unsophisticated to admit this. This doesn't change the truth of the statement. Being honest, considerate, caring and trusting is good for the building of meaningful human relationships. This is so in business and out of it. It also makes sense for rational reasons. Operating out of a basis formed by trust is likely to save both money and time. Without trust, respect, consideration, care, integrity, honesty, unity of vision (through sharing in the process of creating it), long term partnership is nigh impossible. This has important organisational implications. Both management and those other parties represented within the employment relationship need to accept and express these realities more readily, where possible, in the practice of organisational life. Treating others in this way is also far more likely to induce volitional responses and discretionary effort from them. It is probable that through no other method can a person be encouraged to work closer to their optimal or highest level.

Again, these principles are not new, merely restatements of long-held principle. They remain ever needed to be implemented within groups of people for those organisations to operate successfully and beneficially to their members. Over later years it has been regular for commentators (e.g. Wayne Casio) to point out that many change operations do not achieve their intended results. The cause of this might have something to do with the lack of positive values being instilled into organisations as a result of the change programmes being implemented. Considering principles based on the above mentioned interpersonal qualities could dramatically rectify this situation.

In Canterbury Health Ltd, this might have applications in the following area: the need to have clinicians understood and involved at the highest levels of management. The management of health requires managers who are well schooled, skilled and sensitive in dealing with health issues specifically and who also understand clinical, developmental perspectives on change.

Many hospitals are actively pursuing strategies that integrate physicians into their management and governance structures. Despite expectations that these collaborative governance structures improve hospital efficiency, empirical studies have failed to provide consistent evidence that physician involvement in hospital management and governance improves hospital efficiency (Alexander & Lee 1999). Nonetheless, this kind of co-operation makes intuitive sense for the betterment of such organisations,

certainly on the basis of internal factors such as a healthier work climate and improved staff-industrial relations.

Competing values systems may moderate the relationship between physician participation in hospital management and hospital efficiency. This is because the conflict and distrust inherent in this schism could lead to non-significant performance increases because of competing goals and cultural differences. One thing is sure, more professional trust is needed between clinicians and management. Trust is a key element of effective work relationships between managers and physicians. Strategic change in health organisations requires collaborative leadership involving constellations of actors playing distinct but tightly knit roles. In doing this, it needs to be appreciated that collaborative leadership is fragile and can easily disintegrate due to internal conflict or to discreditation associated with unpopular change tactics.

The economic virus that has infected the body politic needs to be restrained and controlled in the social domain that health is. Market ideology cannot be allowed by managers of health systems to infiltrate public policy to the overwhelming detriment of individuals in the practice of that policy. If this is to happen, then managers and politicians that want to make decisions with clinical ramifications should have the same accountability as doctors.

The egocentrism of our extroverted Western culture has affected management groups in a negative manner. It is up to the individual and the individual organisation to resist this. To apply an approach akin to the Jungian psychology of the individual person to the subject of organisations, the introversion of the soul or Self is frequently repressed or disallowed from coming out for ego-based reasons of defence. For this metaphor's purpose, the view of the clinicians can be seen to represent the soul. This negates the soul or Self's influence and leads to a lack of 'wholeness' and internal congruence in the achievement of real purpose. It is the task of the manager-leader-hero to oversee that this does not happen. Love and selflessness transpire and rise from the Self. These qualities are essential for an organisation to be well from within and not simply to live or subsist. It is one thing to merely survive. It is another to be healthy. Management's role, I will suggest, is to administer organisational life and organisational life in all its fullness.

To do this, a member of management must be aware of the forces and motivations that reside deep within the Person. Heraclitus, the Roman historian of antiquity, makes a compelling argument for evaluation of the Person or Self by the individual, be they

manager or not when he said, "the soul is dyed the colour of its thoughts. Think only on those things that are in line with your principles and can bear the full light of day. The content of your character [and by implication managerial action] is your choice. Day by day, what you choose, what you think, and what you do is who you become. Your integrity is your destiny". It is my belief that this sort of self-evaluation is needed to be done by individual managers if we are to continue to see genuinely renewed and newly transformed organisations within the times in which we live.

One managerial approach could be based on quality. There is a traditional, intuitively simple model of quality control or accreditation. However, quality control could be quite inappropriate in the context of health care (St Leger & Walsworth-Bell 1999). The principles of continuous quality management may be far more relevant because it relies on organisation-wide beliefs, shared values, and teamwork across complex networks. It is also patient centred, assessing results in terms of possible outcome measures such as resumption of normal activities, activities of daily living scales, pain scales, psychological assessment, and patient satisfaction rather than in terms of quantified costs and their impact, mortality rates, symptoms severity, risk factors or complication rates.

A fixation has grown within Canterbury Health Ltd over the last few years with developing protocols and procedures in places where there previously was none. These protocols are to describe in list-form how a medical task is to be accomplished. The problem with this is that clinical staff already knows how the task is to be done. Signing off against the protocol restricts a full expression of clinical decision-making and removes both freedom and responsibility from them. It is an encumbrance that they certainly feel that they can do without.

This preponderance upon rule and procedure is based upon central notions to do with the need for operations to become more streamlined, standardised, and rationalised. It is as much to do with lessening risk through compliance with stated protocol as it is to do with any other organisational or corporate benefit. Physical and tangible aspects of change remain only one manifestation of the process. Issues, such as those of spirit and community, still need to be addressed. These are in line with the developmental approach relied upon through this paper.

Increasing the health of public health management

The major implication that this paper brings to bear on the management of health is that both economic and sociological models of behaviour (as represented in Table 1) need to be incorporated in approaches devised for organisational change and its management within the area. In his time in Canterbury Health Ltd, the CEO claimed more than once that Canterbury Health Ltd was a healthy organisation. Some doctors still disagree. Changing this will probably mean putting what has already been referred to as the 'heart' back into health management.

Before the health reforms, New Zealand, at 7.4% of GDP expenditure on health, was in the top seven nations of the world in terms of OECD measurement for the delivery of health care. Post-reform, this has been knocked down to 5.9% and the country has dropped internationally to forty-second place. It has slipped well down despite the increased efficiencies of parts of it. The whole is more than just the sum of its parts. There currently exist a group of clinical colleagues in Canterbury Health Ltd who are determined to put this right and they require the assistance and belief of their managerial counterparts if seeing this come to pass will result.

Market conditions are forcing health care organisations into new and difficult processes of self-examination and change. Many of the traditional and time-honored methods of health care delivery are being replaced due to demands of cost-conscious consumers. For the first time, health care providers are being forced to consider cost when making recommendations about patient care, and providers are finding themselves in competition or conflict with the philosophies of hospitals and other institutions. These differences are causing dramatic changes in the relationships within and among all of the factions in our health care system.

Health is a human profession. This concept has been central to the existence of the health system in New Zealand for many decades, dating back to the origins of this land. It is a concept that has been deeply eroded by the policy and action of successive governments from the time of the Fourth Labour Government. This erosion has not been stalled with the employment of international managers in the management of this domestic health system. These managers variously reflect differing cultural values. New Zealand's historic health system has, thus, become seriously challenged, both from within and without. Part of this imported change can be accepted as a fait d'accompli with the advent and growth of globalisation and multiculturalism across the world at large. Its effects do not have to be tolerated or left uncontrolled, however.

Central government has an extremely critical part to play in negating undesirable influences in the health system.

Recent public health disasters, demonstrated all too clearly by an increasingly unsympathetic media, bear this point out. They also show, to a degree, some of the strain that the national health system has been put under by its reform. Examples of this type of system failure have been the dirty endoscope saga at Christchurch Hospital, misdiagnoses of cervical smear results in Gisborne, similar issue with respect to prostrate cancer and breast cancer screening in other health districts, and problems with colostomy procedures elsewhere in the country. These mistakes have been disasters both for the public and the public relations of the institutions involved. They could well be symptomatic of the failings of a management system primarily disassociated from a primary concern and love for people as patients, rather than payers. Certainly the public view these not so much as medical failures (although medical misadventure on a private basis is a growing concern) but rather system and management failures. That is to say, outcomes of poor administration and management decision-making and all this at a time marked by the outward aim for efficiency and organisational restructuring.

In New Zealand health and hospital service leaders need to continue to evolve from the traditional passive health management style, using transactional management skills to balance historically-based expenditure budgets, to active, transformational leadership styles that balance and reflect a stronger developmental, human focus and economic orientation (requiring active management of other resource including a return on investment, identification of costs and returns, marketing, reducing non-core activities and overhead costs, and a closer relationship with shareholders, suppliers and customers/clients).

As a new era for health care emerges, organisational leaders will be required to manage increased levels of risk, uncertainty, and rapid change. Successful chief executives will be those who recognize and nurture intangible leadership qualities including knowledge of self, commitment to service, and depth and breadth of vision. With the continued shift away from hospital inpatient care, health care leaders will be called on to develop multipurpose delivery systems that move from a market-based to a community-based focus and deliver high quality services in a cost-effective manner. Several leadership themes will unfold in the midst of this. Exploiting change for the good of the organisation community; serving as educator, communicator, and

comforter to divergent constituencies; and reestablishing a balance between short-term goals and long-term vision.

Recent years have witnessed the dominance of managerial rationality. Both management by rationality and logic, connected as it is with an economic approach, and leadership with values and passion, bearing clear association with a developmental approach, are required in today's business environment if sustained growth and organisational enrichment are to occur. In many cases, the latter is being shown to be a precursor in practice (Tsui 1997). This means that solid bottom-line analysis should be the complement of intuition, not the rival. They are both vital parts of the multi-faceted jigsaw that leadership is.

The antagonism between clinical staff and management is wrested in the tension between these apparent opposites. They should not be in competition as opponents, however. Emotionality and spontaneity are the distant but still first cousins (only too far removed in practice often) of order and planning. Leadership demands them both. This connects head (thinking) with heart (feeling) (Olson 1990). Managers tend to lean on their 'thinking' function and not allowing synthesis or transcendence through reconciling this function with its 'feeling' opposite. This former function stresses order, time schedules, and tangible accomplishment at the expense of the subordinates' values (Olson 1990). Managers need to be feeling thinkers.

A contradiction seems to have existed in health restructuring. Management has considered the prime loyalty of health staff to be to management, which was governed by commercial dictates. For staff, however, the prime loyalty was to patients. Health management, all too typically, deals with the issue purely as a traditional employer. They would be better to remember the profession they worked in.

There are strong arguments for having clinicians as part of management, not the least of them cost control. Because doctors use health resources, it makes sense that they should also have some say in containing those costs. Indeed, some medical staff have chosen to take part in management precisely to exercise more control over their own destinies and those of their patients.

In leading and managing change in a people-based sector, such as health is, senior managers need to adopt a balanced view to priorities that itself is based on both approaches of developmental and more classically rational economic considerations. In Canterbury Health Ltd's case, this would require tempering what comes most easily

on a natural basis (i.e. acting in a 'top-down' fashion) with what is most effective upon an organisation-wide scale, with the social web considerations of the latter. One approach to management without the latter lacks efficiency. The other, without its appropriate complement, lacks efficacy.

Raising tolerance and innovation

As already alluded to within the body of this paper, it is the belief of the author that local human resources management has a huge prospective part to play in developing the culture of the organisation that Canterbury Health Ltd represents. It is held that it is not just the role of human resources management to facilitate this but that it should be the role of this section of management first and foremost to develop this part of the organisation in conjunction with corporate staffing.

Hendry (1999) claims that the study of the management of change is all too typically focussed upon the political aspects of the change process. He describes this as "atheoretical pragmatism" (1996: 621). The author makes the open acknowledgement that this paper has taken a view toward change that has approached change from this perspective. Upon his suggestion, within this section a consideration of the change management process will be made from a position of placing learning theory more centrally within the definition of planned organisational change and with a view to making further recommendation to the management of Canterbury Health Ltd as to how this theory might help it to effect more effective change over future years.

"To reshape a health system without due regard for cultural imperatives is to risk failure" Hornblow (1997:1892). A consideration of cultural impact appears to have been a neglected aspect within the way that change has been managed by senior management within Canterbury Health Ltd over the last decade. Cultures have been polarised within Canterbury Health Ltd over the last decade (Hornblow 2000) and, while some positive progression has been made in relations due to the pragmatic consideration of individuals, much room has to be made up in terms of establishing cooperative decision making (Hornblow 1997).

"A major challenge now facing the ... health sector is to re-establish co-operative decision making between the clinical and commercial sub-cultures [of that sector]" (Hornblow 1997:1894). The lesson to learn is that good health care depends on staff and management working in an atmosphere of good faith. The new business culture of

health care has led to conflict between the core values of clinical staff and management. The central focus of the two roles is essentially different and this is at the heart of the conflict. The need for mutual understanding and collaboration will be a means of reconciling these differences. Therefore, hospital management must empower their staff, and let the people who work there help to find solutions to problems.

Diversity not unilaterality is needed for a deep and rich organisational culture. Involvement and trust have already been identified as neglected areas of possible gain in this respect. Others include cultural development through acceptance of creativity and acceptance of innovation. Ferris (1988) speaks of the role that vast human energy accepted in love can play in achieving paradigm shifts. This cultural acceptance can be facilitated through a different use of parts of the human resource management function already in existence.

Local HRM could use group think tanks and brainstorming sessions to begin to facilitate acceptance and development in this way. The huge importance of this internal acceptance has tried to be underlined throughout this paper. It is required in order for organisational 'wellness' to eventuate. Single-loop learning is rules-based. Double-loop learning is insight-based. Triple-loop learning is principles-based.

Sengian thinking about the manager and leader as a designer, teacher and steward might be of relevance here. The role of this body is to encourage the creation of personal or individual vision. They communicate and ask for support. They blend corporate vision together from these smaller sets of vision on an ongoing basis. They are prepared to risk in and, more importantly, to trust others. They use thinking based on the whole system not just on 'snapshots'. This might involve redistributing power. Few have the courage and patience to move ahead. Those who succeed gain unique advantages, because they harness the imagination, spirit, and intelligence of people in ways that no authoritarian organisation ever can (Senge 1999). There is power in these thoughts and the power of a playful spirit at work should not be underestimated.

In the search for the sacred, people are looking toward every aspect of their lives for fulfillment and a sense of meaning. This has left a paradox: to expand the bottom-line, organisations sacrifice meaning and value-oriented purposes. People in most organisations serve as the organisation's soul. Often this soul is forgotten in the quest for profits (Robinson 1995).

It is the contention of the author that this inclusion is needed, indeed vital, in the creation of healthier working environments within HHS's in our country. Both economic and developmental ends can be achieved in a matter of some balance. Rotational leadership, involving clinicians, is likely to help achieve this. For the only way forward is managers and doctors understanding each other, helping each other, working together to define the parameters, to define how best to save the money, to work together to the same cause.

"There are a huge number of good people within Canterbury Health Ltd. They just need a framework [under which] to move forward."

(Respondent quote)

"We can say things till the cows come home and people won't listen but they'll watch what you do and that's what counts."

(Respondent quote)

"Yes, there are two paths you can go by/But in the long run there's still time to change the road you're on."

(*Led Zepplin* lyric)

CONCLUSION

The focus of this thesis is the general management process associated as it is with the management of broad change rather than only (but nonetheless still combining) specific areas of decision making. This thesis has grown out of the simple aim of trying to relate the body of research findings and writing on the subject of the management of change to the practical problems encountered in managing such change within health provider organisations. It has also endeavoured to provide a 'snapshot' of how Canterbury Health Ltd has managed change over the last four years, integrating both clinical and management perspectives.

This paper has taken the form of an investigation into the relevance of models of change management to an extensive and detailed case study of change management as understood by managers in that organisation. The analysis and discussion of this paper is rooted in the belief that existing approaches in the management of change literature is rather limited and based on a view of managers as essentially scientific in their approach to problem identification and resolution. This study, on the other hand, is based on the conviction that we need to understand management as a social, political and cultural activity.

Little planned and eruptive transformation has occurred within Canterbury Health Ltd over 1995-2000. Most of the changes that have taken place within its greater institution have been incremental and isomorphic (or driven from without rather than within). The heavy effect of the outer environment on the functioning of components

of the health system has duly been noted. No significant and both positive and unplanned change was observed.

The major aim of this thesis has been to consider the extent to which the conceptual framework of Part I helps to explain the phenomena of behaviour and change management as observed in Canterbury Health Ltd over the period under scrutiny. A second has been to develop explanations for the processes of managing change in health and hospital services that arise from an analysis of the in-organisation study. Implications from this analysis have been suggested which, it is believed by the author, better serves both the internal and external constituents involved in this process. The role of continual organisational development and a developmental approach to the management of change is implicit within these recommendations.

The central finding of this paper confirms a scientific approach to management as the dominant managerial practice inside Canterbury Health Ltd. That is to say that a predominantly economic approach towards planned change management has been implemented within Canterbury Health Ltd under the regime led by the CEO. Unplanned change has also occurred but this is of less consequence in the immediate context of this paper. This economic focus is characterised by the increasing 'financialisation' of human resource indicators and dehumanisation (in a non-pejorative and literal sense) of patient care. Examples of this are the employment of units of operational measurement such as, capital cost per discharge, worked hours per inpatient day equivalent, direct personnel salaries per inpatient day equivalent, and functional independence elements to describe patient mobility.

For reasons of pragmatic financial necessity and sense, much of this economic approach to planned change management has needed to be so by virtue of the serious corporate pressures that have been brought to bear on health institutions. Equally, however, the need exists to develop the internal culture of the organisation of Canterbury Health Ltd itself to better reflect its changing aims and desirable outcomes in terms of inter-collegial relations. An economic approach to change alone does not recognise this, however a developmental approach to planned change management encapsulates this requirement well. A focus upon this is the single most overriding implication of this paper. More emphasis upon developmental methods in the management of change within Canterbury Health Ltd is needed.

A high need exists for intangibles to be focussed upon in the improvement of internal relations and co-operation. This demands first-class people skills and co-ordination

efforts; the 'soft' skills of what have been regarded as HRM's domain by management generally for the last two decades. Despite the enormity of this task and its continuous, ongoing nature, it desperately needs to be tackled. Finally, this is the overwhelming implication and recommendation of this paper. It is a recommendation that is just as quality focussed as economic, bottom-line determinants. Corporate management has diligently sought these considerations over the last block of time. Cultural and organisational developmental considerations within the organisation now need to be sought after with the same amount of determination.

It is the belief of the author that HRM also has a role to play in helping staff cope with imposed changes. It is a fact of organisational life that many people feel victims of change and HRM has a duty to help them cope with these feelings and return to being productive members of the changed organisation. The degree and the depth to which this occurs within Canterbury Health Ltd were not attested to during this research. HRM practitioners are already involved in the implementation of change and rightly so. This is both through the imposition of already decided change and by participative involvement in the change. Its role in these fields of change practice should not change but expand to include more of the former aspect.

These conclusions are by no means groundbreaking. Nonetheless, it is the hope of the author of this research that this thesis, through argument and analogy, has produced a plausible story. This story can only be understood, indeed read, through the lenses of the parties involved in the current health system. Simply put, there are three aspects to this notion of relevant party: the clinical staff, the public (including members of the public external media), and the management staff within the health system context. Careful delineations between the perspectives of these parties have been represented. Neither of these major party's perspective is entirely correct. A line needs to be drawn between them. It remains the author's hope that the implications drawn within this paper are both functional and balanced between the economic and human products of organisational process for all perspectives and both of these ends are required to be maintained within organisations.

Change within this environment, and as it has impacted upon Canterbury Health Ltd, over the last five years has been both of the planned and emergent variety. There are two sides to the face of the coin of change. Thus, the nature of change is paradoxical. Population ecology theory bears this out with its inherent duality of birth and decline. These two elements co-existently reside within all change processes. Death is a fact of life. The one bears meaning to the other. Such complementarity exists all around us,

not the least in situations of organisational change. In discussing the duality of change, Van Maanen ed. (1998) emphasises the creative-destructive facet to its nature.

So, managing change is not as systematic as it is can be seen to be sometimes represented as being in academic theory. Indeed, change is not nearly so implemented as prescribed by theory as it is the product of both planned and unplanned elements, personal, interpersonal, collective, political and social forces. Change is a relative affair. It occurs over periods of time, both short and long. The degree, nature and extent to which change happens over time is a contentious issue. Some see it as a product of process both planned and unplanned. Pettigrew, for example, argues for a processual view of change that regards change as only being able to be understood in the context of large blocks of historical time. This has been the view of this author and Canterbury Health Ltd's experience of the last five years can be seen to demonstrate this.

It is however quite possible that change can be understood as being non-processual in nature. From this perspective, change appears instantaneously as a result of a historical set of precursive events. The difference might be semantic. What one can say for certain is that change can *appear* to happen both quickly and rather more slowly. Change is relative to *perceptions* of change. It is predominantly a perceptual phenomenon, understandable only in terms of individuals' accounts of definition of the situation (Wilson 1995).

In discussing organisational change what is really meant is the degree of change taking place rather than assuming that change is the antithesis of some assumed stability. Everything is subject to change, however apparently stable its nature. The same is true of organisations. Some appear to remain unchanged over a number of years, yet they are constantly evolving in time, sometimes by accident, sometimes by design. Physically, the organisation may look the same. Canterbury Health Ltd can be seen to fit into this general category.

Will the next decade see the failure of market-based health economics and management?

Dannin (1997:233) describes the current prevailing liberalised economic system of management in the following terms: "This system requires the abandonment of reason and the ability to hold complex views. Its signs of grace are economic figures. It cannot see and thus ignores the non-quantifiable. Unfortunately for those who live

within the system, most of what makes life worth living is unquantifiable." Health management systems cannot afford to ignore this. Efficiency is a double-edged sword. It possesses a negative flipside. Winning financially is often at the expense of people. This schism of 'head' and 'heart' in the actions of managers produces sterile and unproductive outcomes. A new reification of management needs to be endorsed at the state-level. Glorifying those who act in a way that balances these extremes is needed – they are the leaders of the future. Both stewardship and social responsibility are required, not one at the expense of the other but both together.

It is for this reason that the seeds of Canterbury Health Ltd's future, especially that of Christchurch Hospital, might well lie in the CEO's ostensible managerial 'success'. While on the surface it may appear otherwise, an inclination could reasonably be that in the main change occurs despite, not because of, the actions of managers. If the above mentioned and somewhat paradoxical 'failure' occurs then this theoretical view can be viewed to hold some validity.

Within this paper, two generic approaches to the management of change are used to analyse the manner in which change has been managed in the system of Canterbury Health Ltd over its last period of formal leadership. An economic approach has predominantly been utilised in practice by its managers. Issues of culture have generally been sidelined and neglected at the expense of improvement in other, more system-focussed (as opposed to people-focussed) areas.

At the end of the day, a balance is required. Management and leadership are complementary functions. They are interlocking sides to a successful whole in the aspect of cultural development. The tasks of each need to work together on a daily basis and in order for internal, cultural stability to be increased in coming years. Neither is as good on their own compared with when they are utilised in tandem. While desirable, an individual need not be composed of both management and leadership traits. It is natural that either one or the other dominates. An individual must aim for a balanced outcome nonetheless, both with other individuals and within themselves.

For this reason, both developmental and economic approaches might be required at once, although at different levels, within the management of organisational change. This is the final and overarching suggestion of this paper. Clinical workers can be both happy and productive, at once. Indeed, the former is best to be generated through the use of the latter! A choice does not need to be made in the mind of management

between economic efficiency and cultural development; profit and people. Workers, rightly aligned, motivated, trained and developed, can respond very well to the achievement of organisational goals (Pfeffer 1998; Huselid 1995: Hackman and Oldham 1974; Huselid & Delaney 1996).

In the opinion of the writer, the real journey or voyage of discovery that lies ahead of Canterbury Health Ltd consists, not in seeing new landscapes, but in having new eyes[2]. Ideally, and where situationally possible, organisational change based on internal consensus (more so than that which relates to external stakeholders) and the fostering of mutual goals between management and the workforce seems to be the most successful approach to the process of managing change, both in terms of human and financial considerations. This recalls Mary Parker Follet's cry in the 1920's for a participatory approach to management that exhibits 'power with' not 'power over' employees, a cry that was largely ignored for decades and still remains a relatively unique *modus operandi* of management. Organisational change, indeed successful life development anywhere, must involve the connection of 'head' and 'heart'[3].

Indeed, this must continue to be seen as the greatest challenge facing organisational management as it enters a new phase in this fresh century. True, liberating leadership is required in order to tap into the 'deep' things related to culture and spirit within the systemic organisational context. Managers need to be doughtier in trying to achieve tapping into these deeper qualities that are latent within their organisations. Indeed, these deeper qualities are much required in an environment that is currently pessimistic as far as medical practitioners and management are concerned, with allegations of poor practice by the former and widespread criticism of the latter in abundance[4].

To make change and not do this, reveals change to be a sham and is, itself, easily revealed. A nineteenth-century poet pointed out, "to change the name and not the letter is a change for the worse and not the better"[5]. Change must make a significant difference. This is the essence of transformation. Otherwise, Alphonse Karr's old

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[2] A paraphrase, the author is sure, of something that Michel Proust has already once said.

[3] For the exposition of this single, beautiful truth, I am indebted for an untold amount to Dr Peter Cammock, Department of Management, University of Canterbury.

[4] For example, see Press, 22/10/00, p.1, 'Plea to give GPs a break'.

[5] Robert Chambers (1802-71), *Book of Days*, vol. 1, June, 723.

cliché is borne out[6]. More often than not, change (of this sometimes lofty and idealisable sort) is quite a transient item to capture. Nonetheless, it needs must remain the goal. It is an imperative for both the survival of organisations as communities of people and the psychologically integrated existence of individuals.

Ultimately, the manner in which change is managed belies the central values and motivation of the change agents involved within it. It is upon this basis that change is judged by those looking on to the change process. Indeed, it is only upon this basis that change is determined and should be considered successful or otherwise - how it impacts upon and its legacy survives *in the long run*. Investment in human capital and other non-capital sources of solution, along with rational economic approaches to problem solving, need to be continually used and explored by management systems in the national health service.

To this end, there exists an ultimate realisation - managers and clinical staff, alike, acting with one purpose and through both a combination of heart and mind inside the New Zealand health system. This is required in order to avoid the legacy of the next ten years being, as it has been for the last, ultimately exposed as a time that we lost our 'soul' to a form of corporate managerialism that actually shouldn't apply to education or health. When all is said and done, New Zealand health management requires the input of far more dedicated and apolitical people who possess no real leanings to the Right or to the Left of the political spectrum but are wedded to the view of adding value to this country and providing the best public health services possible.

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[6] *Les Guepes*, vi. "Plus ca change, plus c'est la meme chose. (The more things change, the more they are the same.)"

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